VHN Release 11.2: User Notes v3

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Introduction

Major changes occur to the Clinical Encounter and the Workflow with the 11.2 Release

1. All counties/districts must move to the EHR Clinical Encounter with this release
    1. M&M will offer General Clinical Encounter Overviews by Webex. E-mails will be sent out as each Webex is scheduled
    2. It is encouraged that all Clinical Users view at least 1 Webex prior to implementing the EHR Clinical Encounter
    3. Counties that have not moved to the EHR Clinical Encounter v11.1 are encouraged to request detailed training and assistance with set-up
    4.

to schedule training by the. The Implementation and Training group will schedule the training sessions

2. For counties/districts with work flows in place:
    1. System Administrators **must** review the section on Work flows in the System Administration section
    2. Update the Work flows
        1. Users will not be able to access major functions of the Clinical Encounter is this is not completed prior to being of business on the day of Go-live
        2. The following must be added to each work flow for users to work
            1. Encounter Info
            2. Office Visit
            3. Procedures
            4. Education
            5. Program Details
        3. Optional items or items not required to complete the encounter can be added later.
    3. Updating work flows is the responsibility of the LHD

3. For counties/districts not using Work Flows
    1. M&M will load 1 Default Work flow
        1. Allows users to being work
        2. Structured with only those items required to complete the Clinical Encounter
        3. LHDs are strongly encouraged to implement Work Flows quickly to allow users access to those items i.e. e-charts that are not included in the standard Work flow

2. If assistance creating Work Flows is needed please

3. Review the Maintenance Manual section on Work Flows

4. New Tables
    1. With the release install M&M will
        1. Complete the Adjust function for permissions
        2. Reapply users to any existing roles
        3. Give all users Select permissions on any new tables
    2. LHD is responsible for the following
        1. Review the list of new tables in the release notes
        2. Apply permissions to new tables as they deem necessary
        3. Adjust permissions for users as problems may arise if new table permissions beyond Select are needed.
5. Release install and Incident Creation
    1. Please remember to

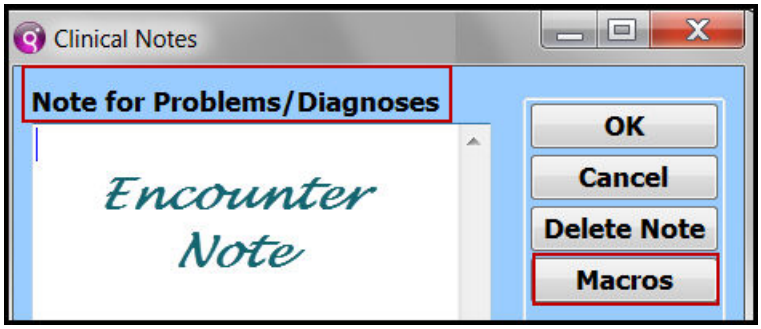
for the release Install
        1. Installation group will schedule a call to coordinate dates and times for Release Installation
        2. Include any plans to implement ancillary functionality i.e. signature pads, cameras or scanning
    2. During release install the tables in Permissions will be adjusted
        1. All new tables will have select permissions only
        2. It is the responsibility of the LHD/System Administrators to complete editing permissions based on the new tables listed in the System Administrator Notes

Clinical

Macros

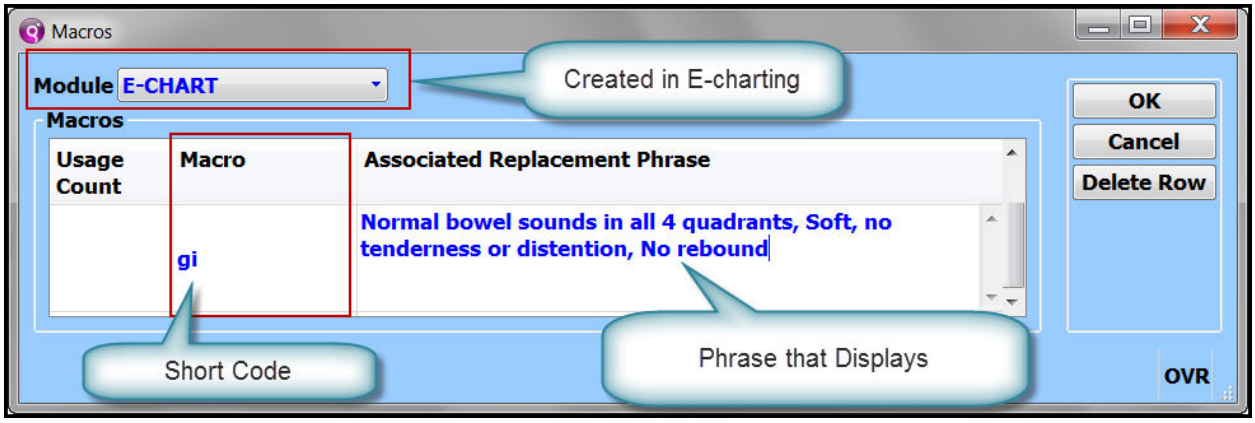
1. Macros added to all note fields to provide users with shortcuts for long strings of documentation
    1. Each macro is established by a user
        1. Macros are user specific and are not available to other users
        2. Macros are currently found in 3 areas
            1. E-charting notes
            2. Encounter notes
            3. Progress notes
        3. Macros can be used across the 3 areas by the user
    2. E-charting notes
        1. Note Fields: Limited to 512 characters
        2. Under the Pencil/Flag note button
        3. Not available on Text fields (short answers of 20 characters)

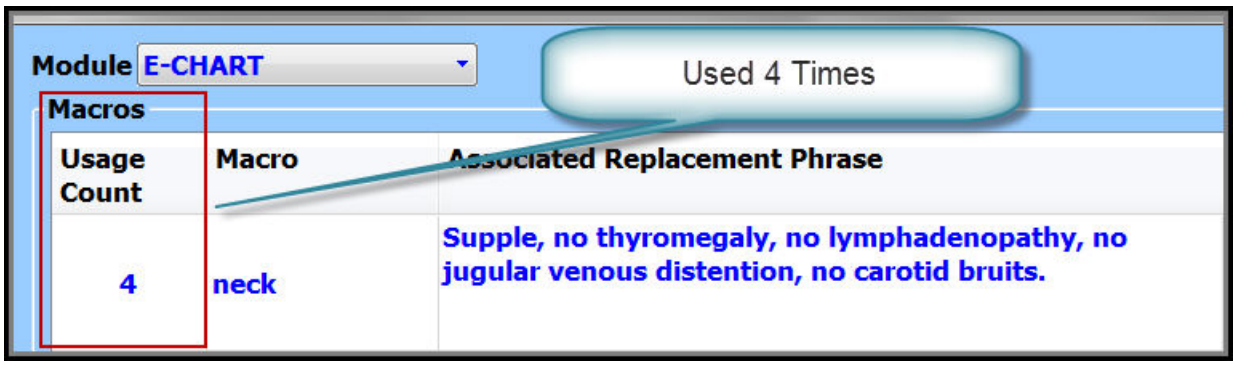
    3. Encounter notes
        1. Unlimited number of characters
        2. Available from any area of the encounter note
        3. See section on Clinical Encounter



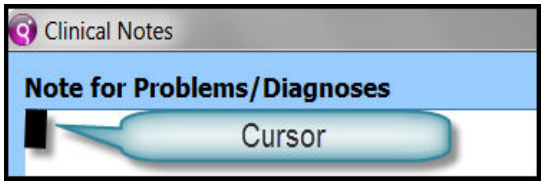
4. Progress Notes
    1. Unlimited number of characters
    2. Available in New, Amend and Addendum
    3. Review current User's Manual for Progress Notes

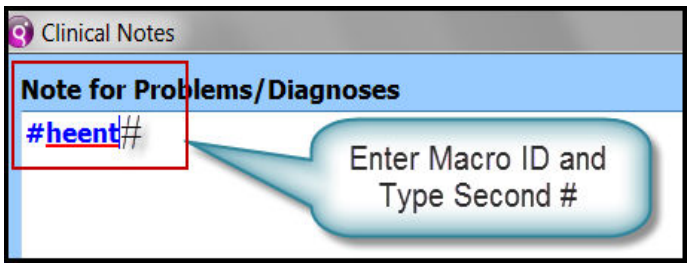
2. Creating Macros
    1. Select the Macro button from any of the 3 areas
    2. Click Add/Update
    3. Enter a code
        1. Should relate to the phrase or text that it represents
        2. Limit the number of characters for the code. This is a short cut
    4. In the Associated Replacement Phrase enter the needed text
        1. If used in an e-charting note be sure to limit to 512 characters
        2. Additional text can be entered in the encounter note
        3. Click OK
3. Usage count
    1. Displays the number of times the phrase has been used
    2. Macros used most frequently will display at top of screen

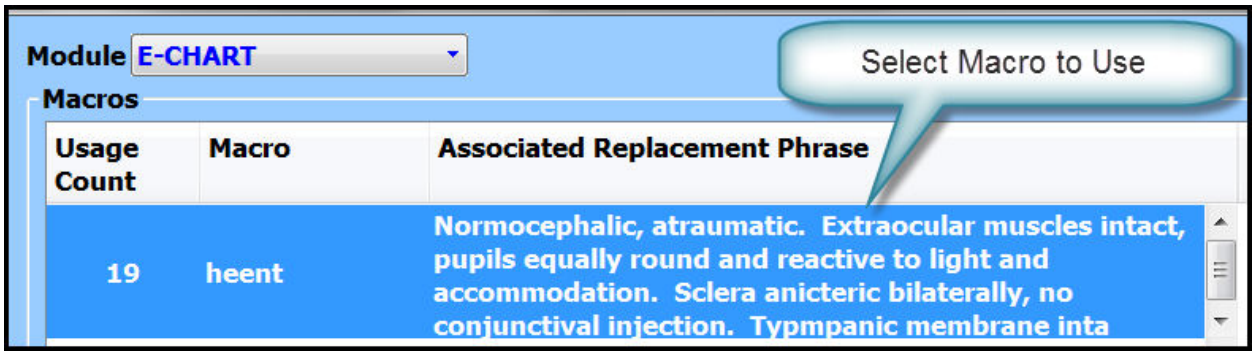


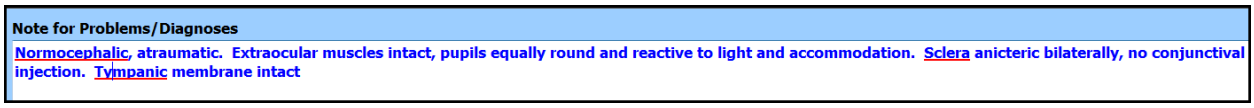


4. Using Macros
    1. Macros can be used across the 3 sources: E-charting, Encounter, Progress Notes
    2. Consumer Patient macros are established by M&M and cannot be altered or deleted
    3. Inserting
        1. Using a tag
            1. Place the cursor in the note field
            2. Insert the macro ID/Code as a tab: #macroid#
            3. Text Phrase inserts when the second # is typed
        2. Selecting from the Macro Table/List
            1. Place the cursor in the note field
            2. Click the Macro button
            3. Select the Macro to use
            4. Click OK
            5. Text phrase inserts into the note

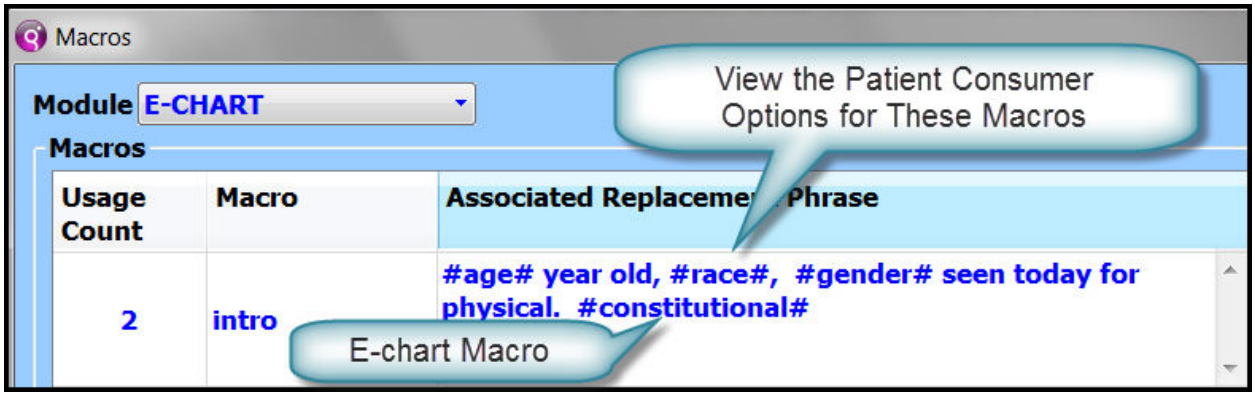




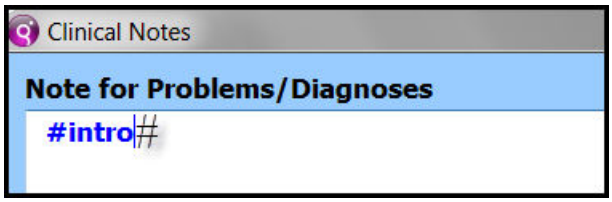

Module E-CHART
Select Macro to Use
Macros
Usage Count
Macro
Associated Replacement Phrase
19
heent
Normocephalic, atraumatic. Extraocular muscles intact, pupils equally round and reactive to light and accommodation. Sclera anicteric bilaterally, no conjunctival injection. Typmpanic membrane inta


Note for Problems/Diagnoses
Normocephalic, atraumatic. Extraocular muscles intact, pupils equally round and reactive to light and accommodation. Sclera anicteric bilaterally, no conjunctival injection. Tympanic membrane intact

5. Using Macros to create other Macros
    1. Click the Macro button
    2. Create the Macro
    3. Insert the text to be use
        1. From the Consumer Patient Module
        2. From another macro in the list
    4. In the Associated Replacement Phrase enter #macro#
        1. Surround the macro with text, punctuation
        2. Remember text character limits
        3. Inserts a combination phrase

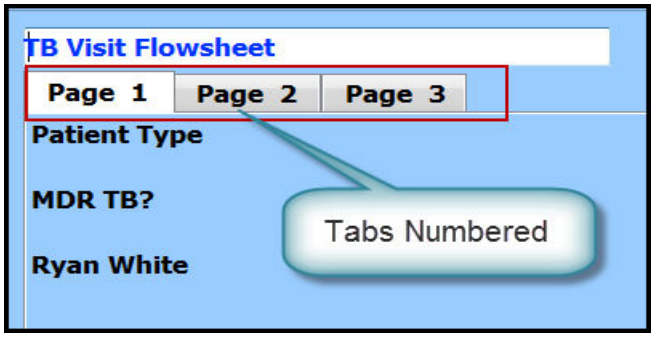


Note for Problems/Diagnoses
Combined Phrase
13 year old, WHITE, MALE seen today for physical. Well developed, well nourished, weight appropriate. Alert and oriented to time and place X3.



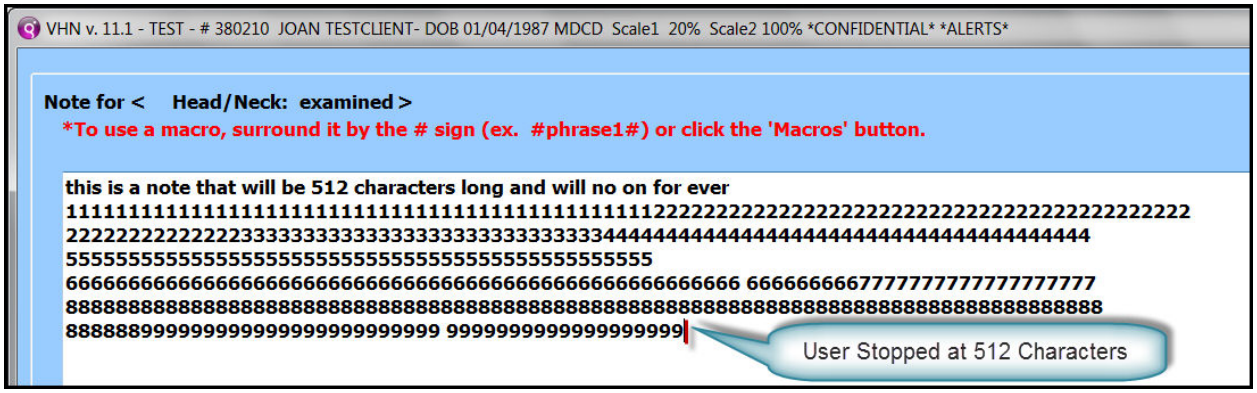
E-Charting

1. Tabbed option only form available
    1. E-charts will now open automatically in Tabbed format
    2. Page format no longer available
    3. Previous paged e-charts
        1. Open in tabbed format
        2. Page breaks will be as before
        3. Tabs will display as numeric values



System administration will need to modify formatting for these e-charts

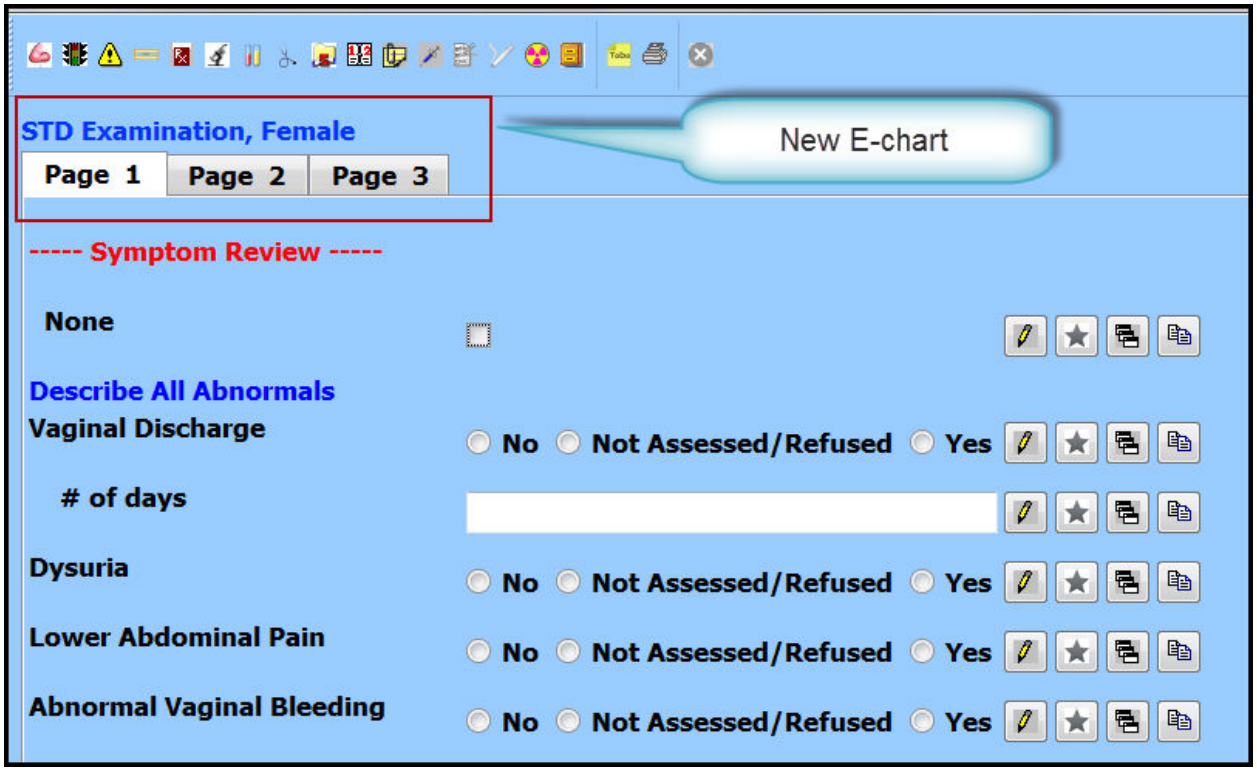
2. Pencil Note display
    1. Note is limited to 512 characters
    2. User is now stopped at the 512 character limit
    3. Recommended that user pull the e-chart into the EHR encounter and enter longer notes there.


VHN v. 11.1 - TEST - # 380210 JOAN TESTCLIENT- DOB 01/04/1987 MDCD Scale1 20% Scale2 100% *CONFIDENTIAL* *ALERTS*
Note for < Head/Neck: examined >
*To use a macro, surround it by the # sign (ex. #phrase1#) or click the 'Macros' button.
this is a note that will be 512 characters long and will no on for ever
User Stopped at 512 Characters

3. New Special options
    1. New options added for users to move through the EHR
    2. Use icons or right arrow icon to move to the screen
    3. Notation inserts into field when return to the e-chart
    4. Reminder: users can move to other e-charts by clicking on the arrow
        1. Message to Save the current e-chart

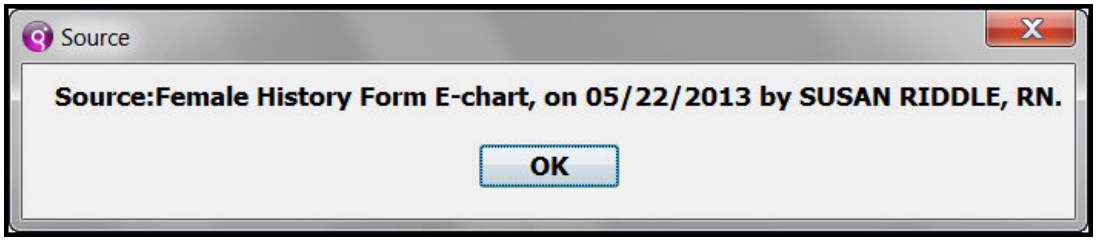
2. Moves to the other e-chart
    1. Becomes a view if the other e-chart has be completed and signed on the same day
    2. Becomes a new e-chart if one has not been completed for that day
    3. Complete and sign if appropriate.
        4. Click Finish to return to the original e-chart in the same tab

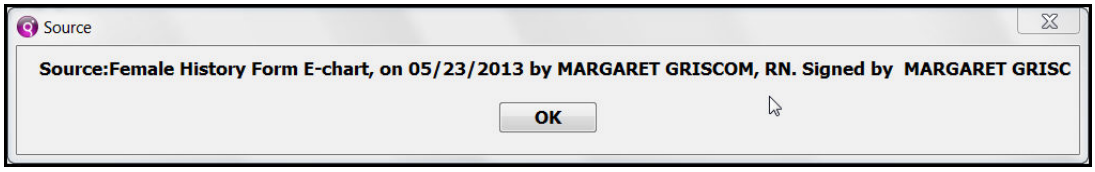
See System Administration notes for set-up



4. Attribution of copied items
    1. Items that copied automatically from one e-chart to another based on set-up will now be indicated with a Purple Star
        1. Click the star and a message with the attribution for that question will display
        2. If the item is changed or modified in any way the attribution indicator will become greyed out
        3. To view the response referenced by the attribution click the file folder button
    2. Items that are not copied automatically will have a greyed out star
        1. To copy an item not from a previous e-chart click the copy button to bring that response forward
        2. The star turns purple and the attribution displays if the star is clicked

3. For e-charts that used multiple times for a patient the attribution may different depending on previous responses and if they have been changed.

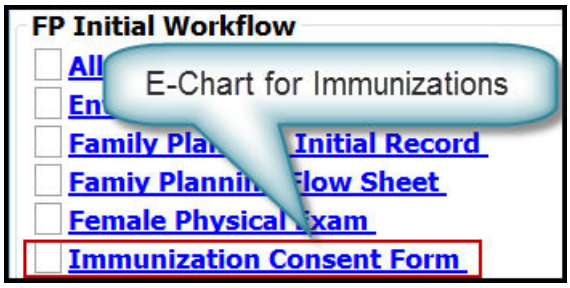


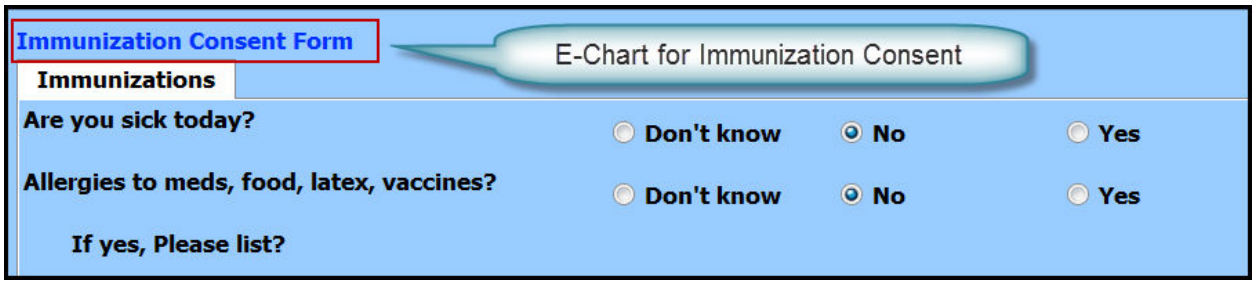


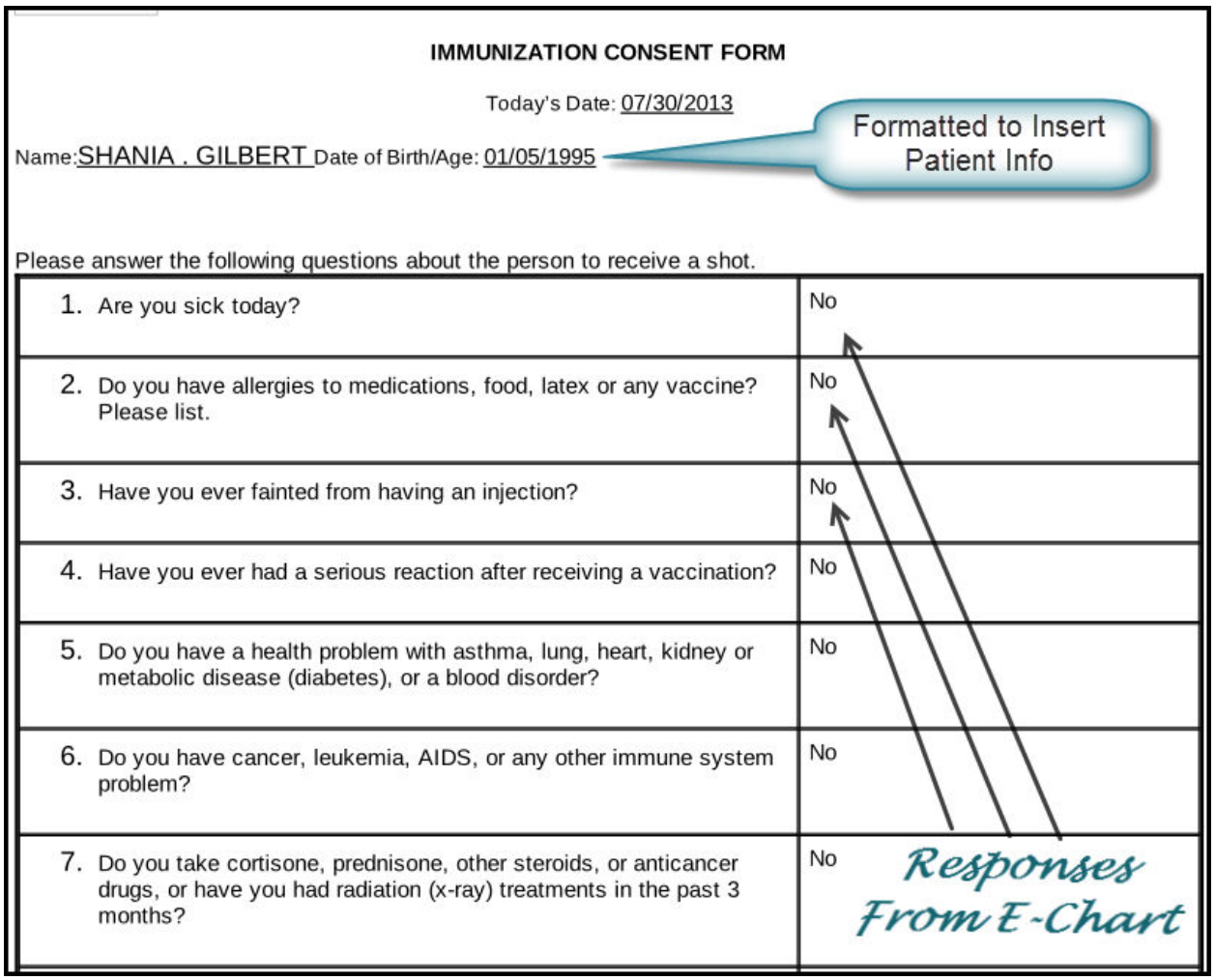
This function replaces the change to the pencil/flag note that was released with an 11.1.1 fix. Pencil notes will return to their original function with the install of the new release.

5. Printing forms
    1. To print a form requiring a signature from an e-chart
    2. Complete the e-chart
    3. Click print
        1. Do not sign the form!!!
        2. The signature application process will proceed based on the form to be printed and who has to sign it.
        3. Form will be stored in the patient's file cabinet and/or can be printed off

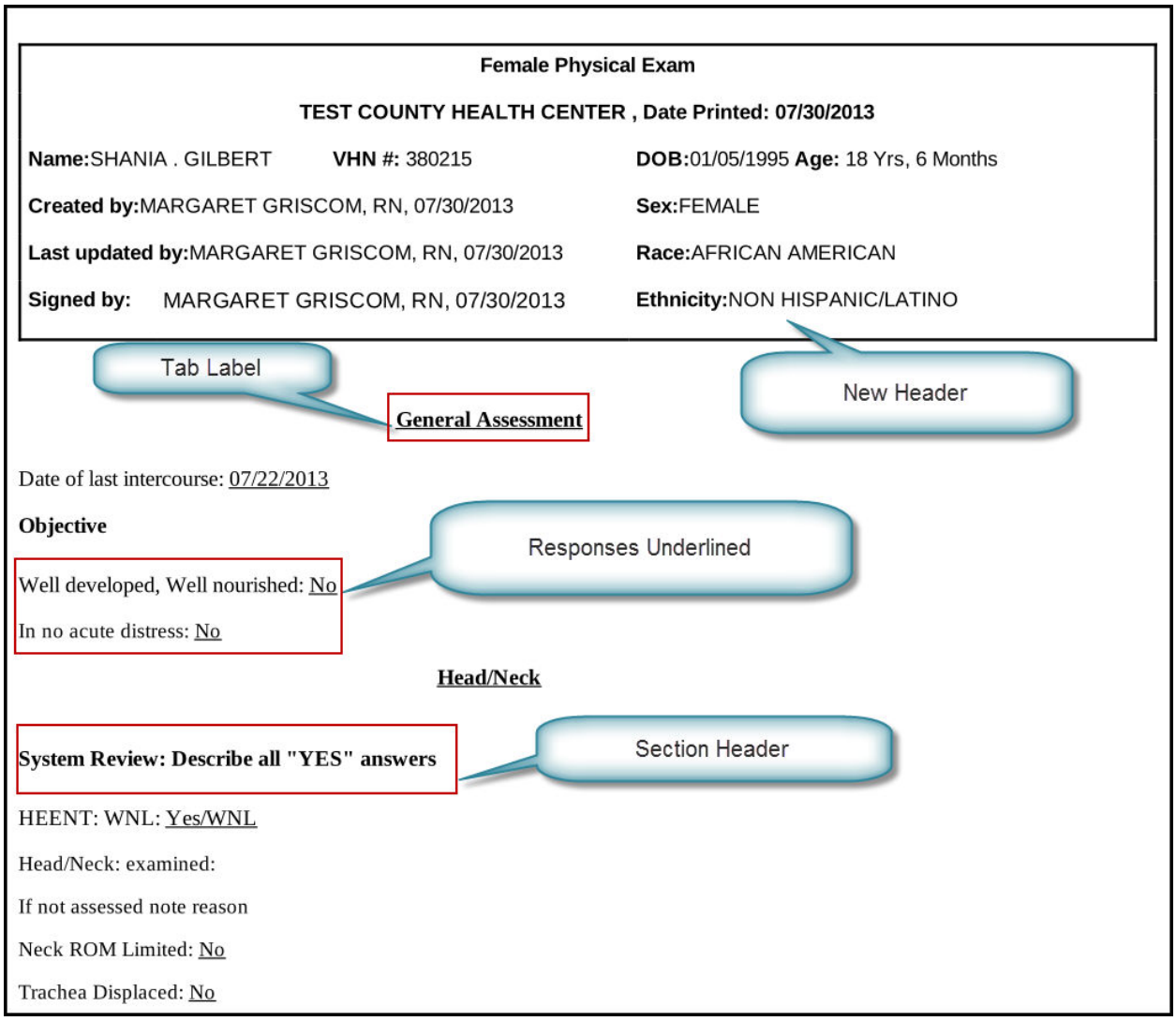
See System Administration Notes regarding Forms. Current form is Example Only






IMMUNIZATION CONSENT FORM
Today's Date: 07/30/2013
Name:SHANIA . GILBERT Date of Birth/Age: 01/05/1995
Formatted to Insert Patient Info
Please answer the following questions about the person to receive a shot.
1. Are you sick today?
No
2. Do you have allergies to medications, food, latex or any vaccine? Please list.
No
3. Have you ever fainted from having an injection?
No
4. Have you ever had a serious reaction after receiving a vaccination?
No
5. Do you have a health problem with asthma, lung, heart, kidney or metabolic disease (diabetes), or a blood disorder?
No
6. Do you have cancer, leukemia, AIDS, or any other immune system problem?
No
7. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation (x-ray) treatments in the past 3 months?
No
Responses From E-Chart

6. Standard forms
    1. Formatting of printout changed
        1. Patient information clearer
        2. Easier to read
        3. Printing clearer


Female Physical Exam
TEST COUNTY HEALTH CENTER , Date Printed: 07/30/2013
Name:SHANIA . GILBERT VHN #: 380215
DOB:01/05/1995 Age: 18 Yrs, 6 Months
Created by:MARGARET GRISCOM, RN, 07/30/2013
Sex:FEMALE
Last updated by:MARGARET GRISCOM, RN, 07/30/2013
Race:AFRICAN AMERICAN
Signed by: MARGARET GRISCOM, RN, 07/30/2013
Ethnicity:NON HISPANIC/LATINO
Tab Label
New Header
General Assessment
Date of last intercourse: 07/22/2013
Objective
Responses Underlined
Well developed, Well nourished: No
In no acute distress: No
Head/Neck
System Review: Describe all "YES" answers
Section Header
HEENT: WNL: Yes/WNL
Head/Neck: examined:
If not assessed note reason
Neck ROM Limited: No
Trachea Displaced: No

Clinical Encounter

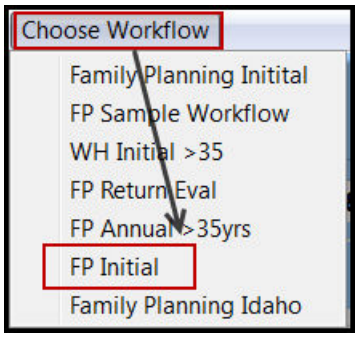
1. All users must move to the Clinical Encounter EHR with this release

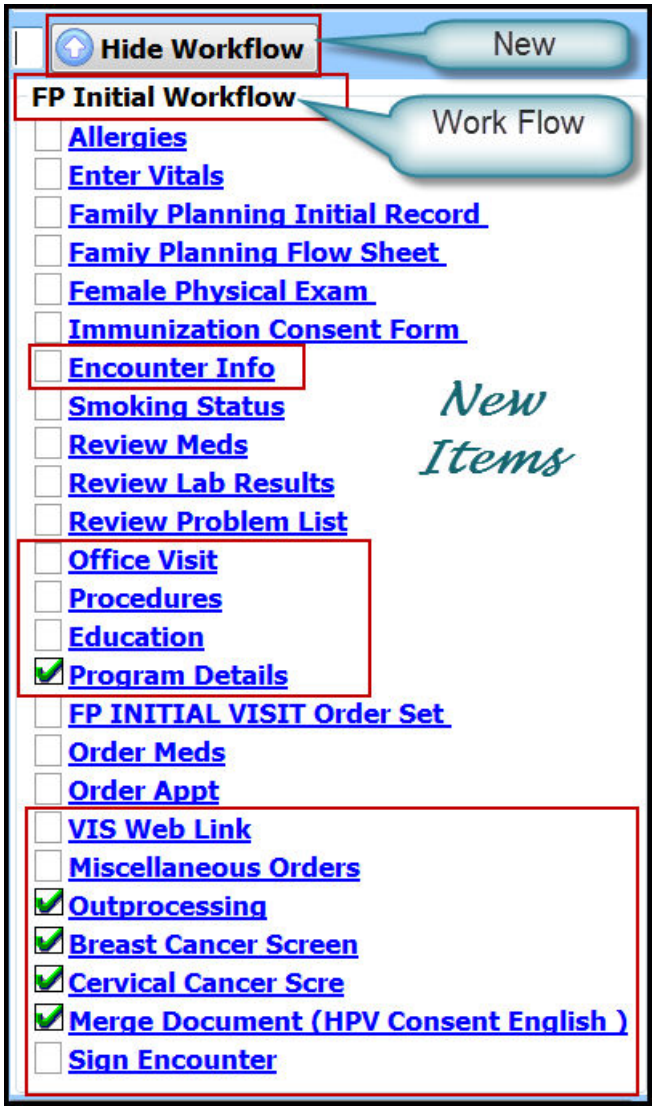
To request training on the Clinical Encounter EHR: Include if requesting web training or on-site training. Include at least 3 dates for the requested training. Also include times available for web training. Someone from M&M will contact the person creating within 7-10 working days to schedule training.

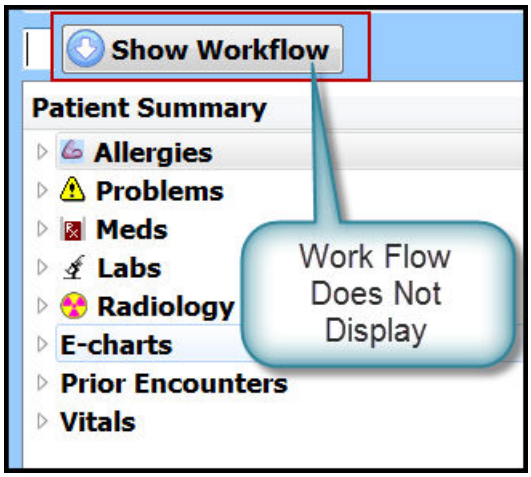
2. Menu buttons removed from clinical encounter
    1. All menu buttons are replaced by tool bar icons
    2. New Tool bar icons:

ICON	Function
	Query
	Previous
	Next
	Remove
	Void
	Review Orders
	Appointment Orders
	Prioritize Diagnosis
	VisReview
	Change Encounter Program
	Check Encounter
	Close then Open New Encounter

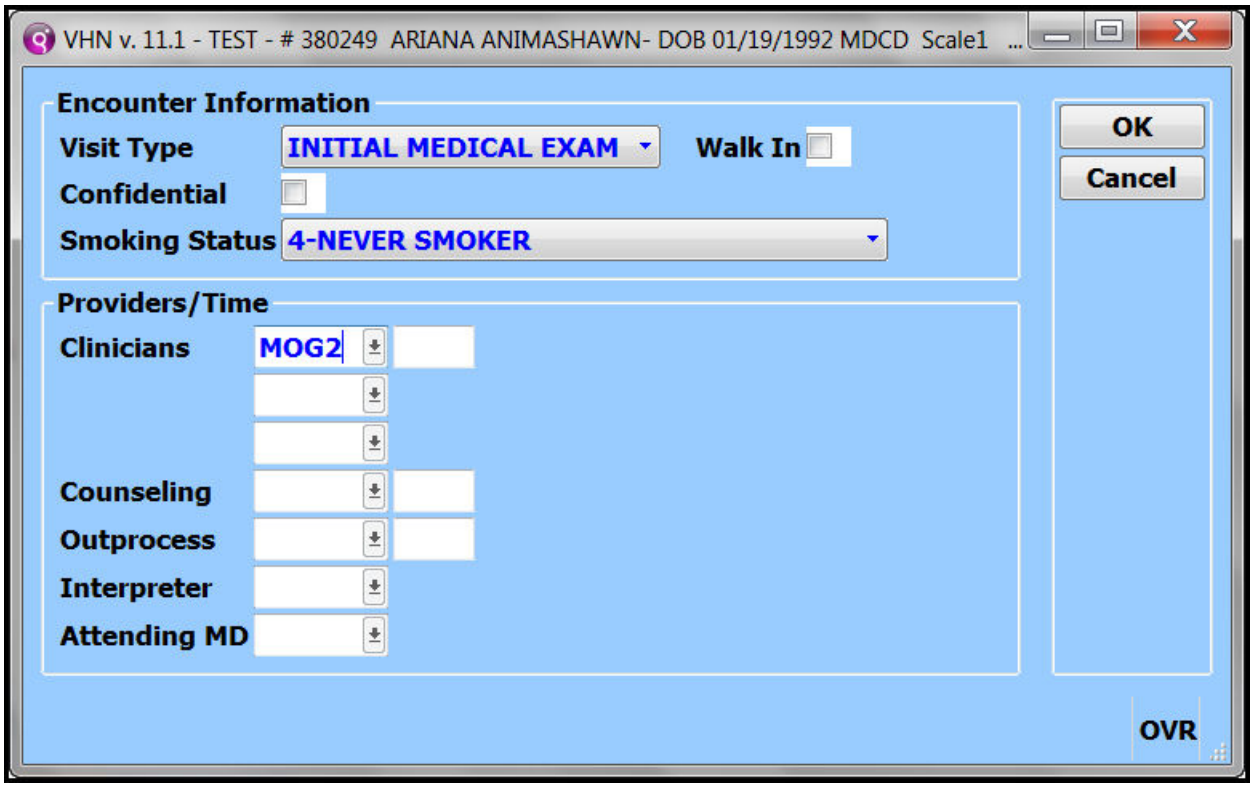
3. Items removed from the Clinical Encounter process
    1. Update
    2. Show/Hide Details
    3. Close Encounter
    4. OK (save)
4. Continued integration of Workflow and Clinical Encounter
    1. Workflow contains all components to complete an encounter
        1. Details section removed from the clinical encounter
        2. Items now included in the workflow
            1. Encounter Information
            2. Office Visit/Problem list
            3. Education
            4. Procedures
            5. Program Details
            6. Outprocessing
                1. Limited Use
                2. Users are encouraged to use the Task List/ToDo List
            7. Merged Documents
            8. Web Links
            9. All review options
            10. Orders
            11. Breast Cancer Screening
            12. Cervical Cancer Screening
            13. Sign Encounter
        3. Must choose workflow when enter the clinical Encounter
            1. Workflow opens in left pane of encounter screen
            2. Items continue to check when completed
                1. Required Items check
                2. Will not check if Time and Activity Codes are not entered
            3. E-charts:
                1. Check yellow when not signed
                2. Check green when signed
            4. New function: Show/Hide Workflow
                1. Automatically shows when user chooses the workflow
                2. Hides when want to see Patient Summary
                3. Click Show to return to the workflow while remain in encounter
                4. If exit the encounter must choose the workflow again


Choose Workflow
Family Planning Initital
FP Sample Workflow
WH Initial >35
FP Return Eval
FP Annual >35yrs
FP Initial
Family Planning Idaho


Hide Workflow
New
FP Initial Workflow
Work Flow
Allergies
Enter Vitals
Family Planning Initial Record
Famiy Planning Flow Sheet
Female Physical Exam
Immunization Consent Form
Encounter Info
Smoking Status
Review Meds
Review Lab Results
Review Problem List
Office Visit
Procedures
Education
Program Details
FP INITIAL VISIT Order Set
Order Meds
Order Appt
VIS Web Link
Miscellaneous Orders
Outprocessing
Breast Cancer Screen
Cervical Cancer Scre
Merge Document (HPV Consent English)
Sign Encounter
New Items



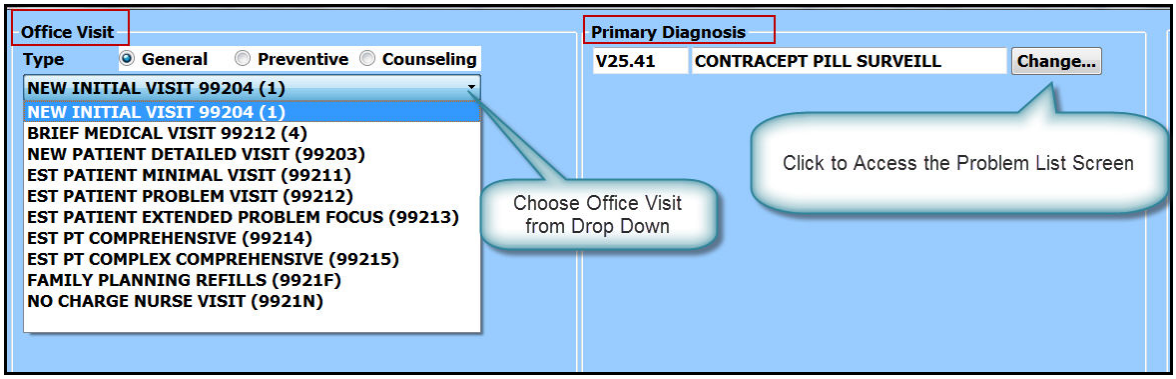
4. Encounter Information:
    1. Visit Type
    2. Check Walk-In
    3. Check Confidential
    4. Smoking Status
    5. Providers/Time



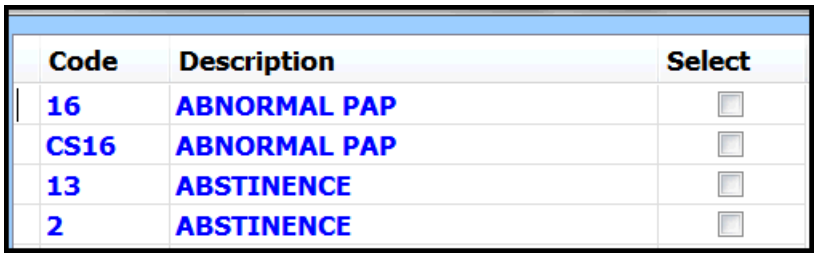
5. Office Visit option
    1. Access to all 3 type of Office Visits

2. Select the Office Visit: General, Preventive or Counseling
3. Use the drop down to select the office visit

6. Primary Diagnosis
    1. Displays the Primary Diagnosis
    2. Click Change to access the problem list
        1. Problem list functions as before
        2. Exit returns user to the Office Visit/Diagnosis screen
        3. Item checked when return to workflow

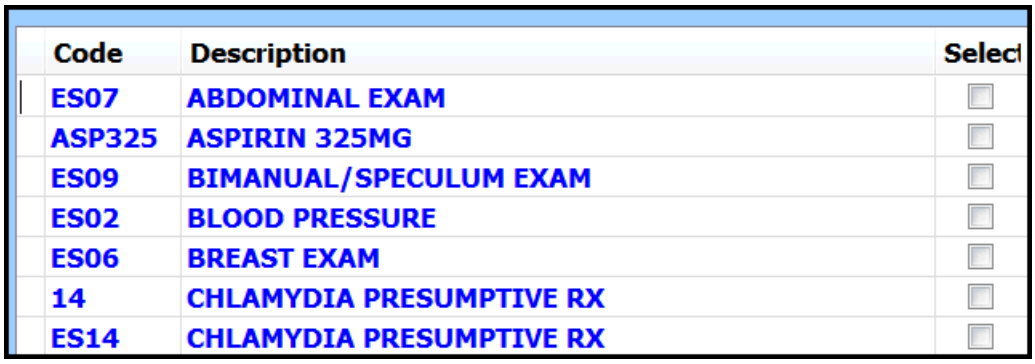


7. Education: Access to the Education/Other Services drop down



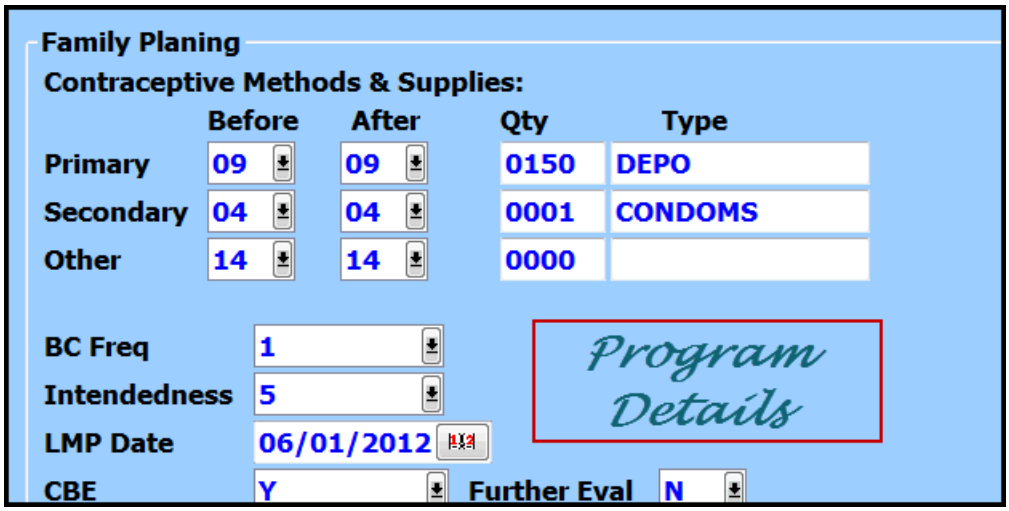
Code	Description	Select
16	ABNORMAL PAP	
CS16	ABNORMAL PAP	
13	ABSTINENCE	
2	ABSTINENCE	

8. Procedures: Access to the Procedures drop down

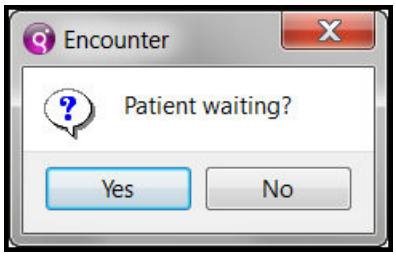


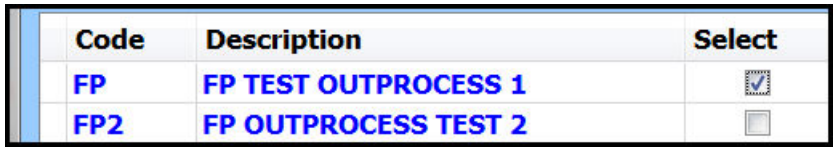
Code	Description	Selec
ES07	ABDOMINAL EXAM	
ASP325	ASPIRIN 325MG	
ES09	BIMANUAL/SPECULUM EXAM	
ES02	BLOOD PRESSURE	
ES06	BREAST EXAM	
14	CHLAMYDIA PRESUMPTIVE RX	
ES14	CHLAMYDIA PRESUMPTIVE RX	

9. Program Details
    1. Takes user to the details screen for the current encounter program
        1. TB
        2. Family Planning

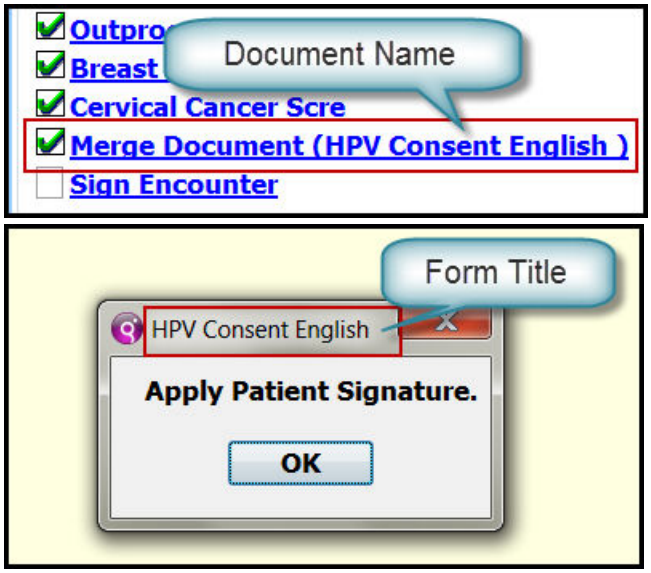


10. Outprocessing
    1. Allows the use of the Out Process orders screen
        1. Patient Waiting message displays
        2. List of orders displays
        3. Checks the work flow



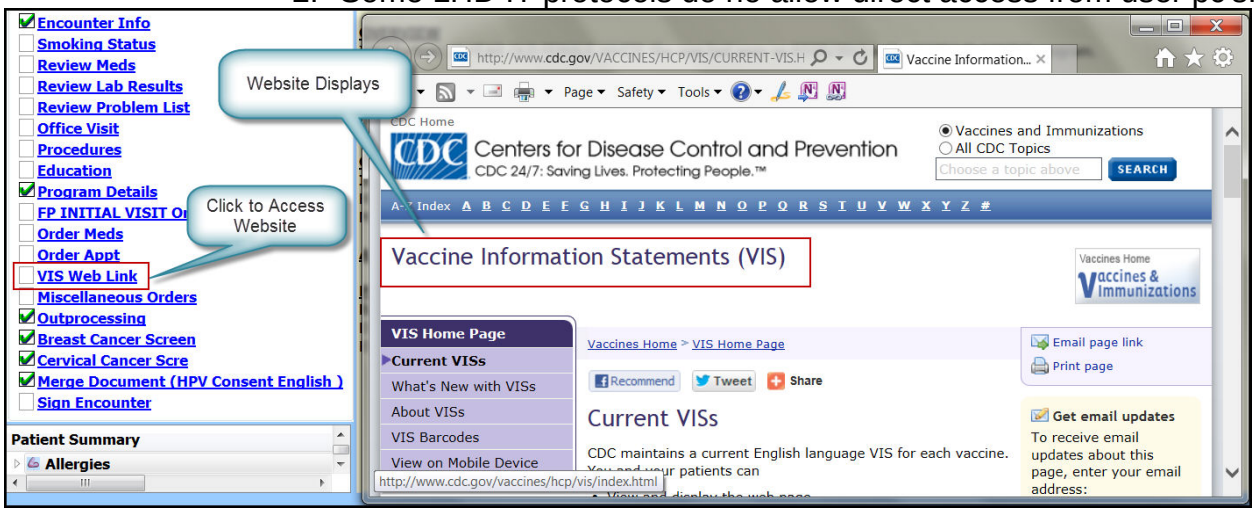


11. Merged Documents
    1. Allows for consents, releases and other documents to be signed from the workflows
        1. **Must** have signature pads available
        2. Forms can require patient and/or provider signatures
    2. Each document that may or not be signed during the encounter needs to be added to the Work Flow
        1. Select the document needed
        2. Using the signature pad apply the patient signature.
            1. Apply any other signatures required for the form.
                1. If signature is required the user must click OK to apply signature
                2. If signature is not required the user has option to apply or not
            2. If a required signature is not collected the form will not insert into the file cabinet
            3. Form will display with



See System Administration Notes for creating documents

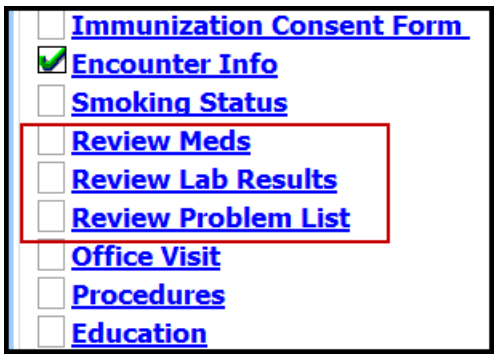
12. Web Links
    1. Provide direct access to websites
        1. Patient Education
        2. Provider references
        3. Protocols
    2. Some LHD IT protocols do no allow direct access from user pc's.



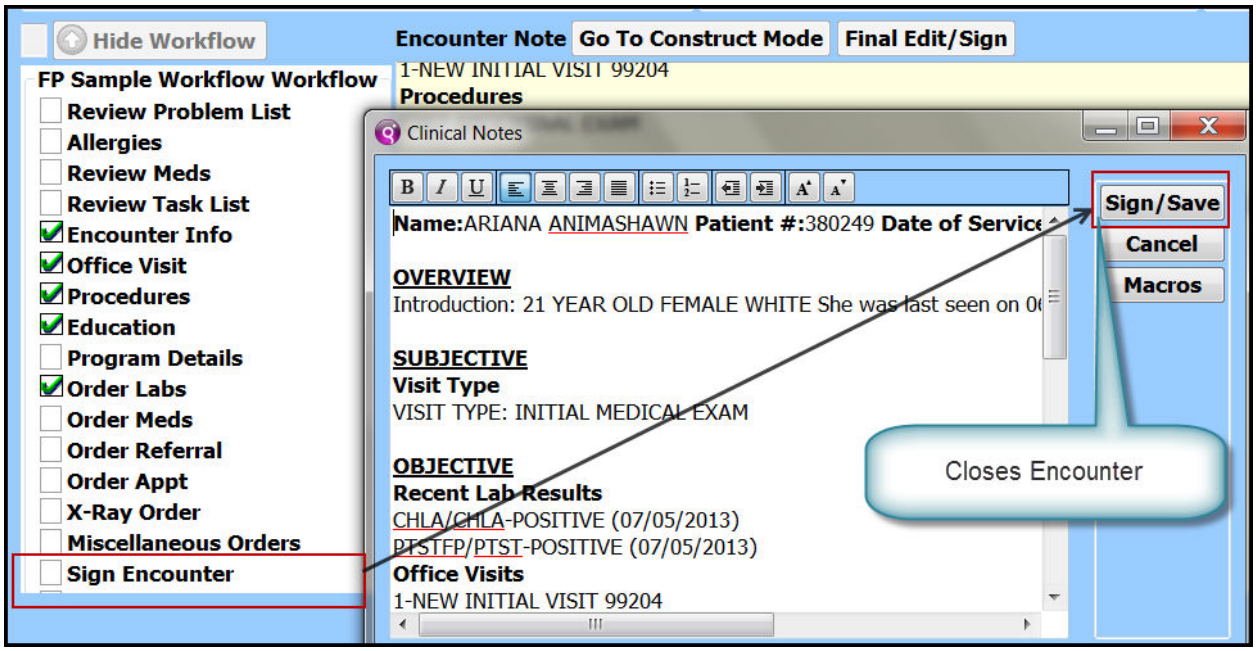
See System Administration Notes for web links

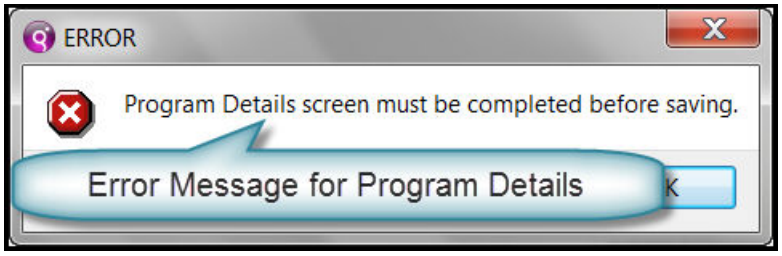
13. All screen Reviews
    1. Lab Review
    2. Medication Review

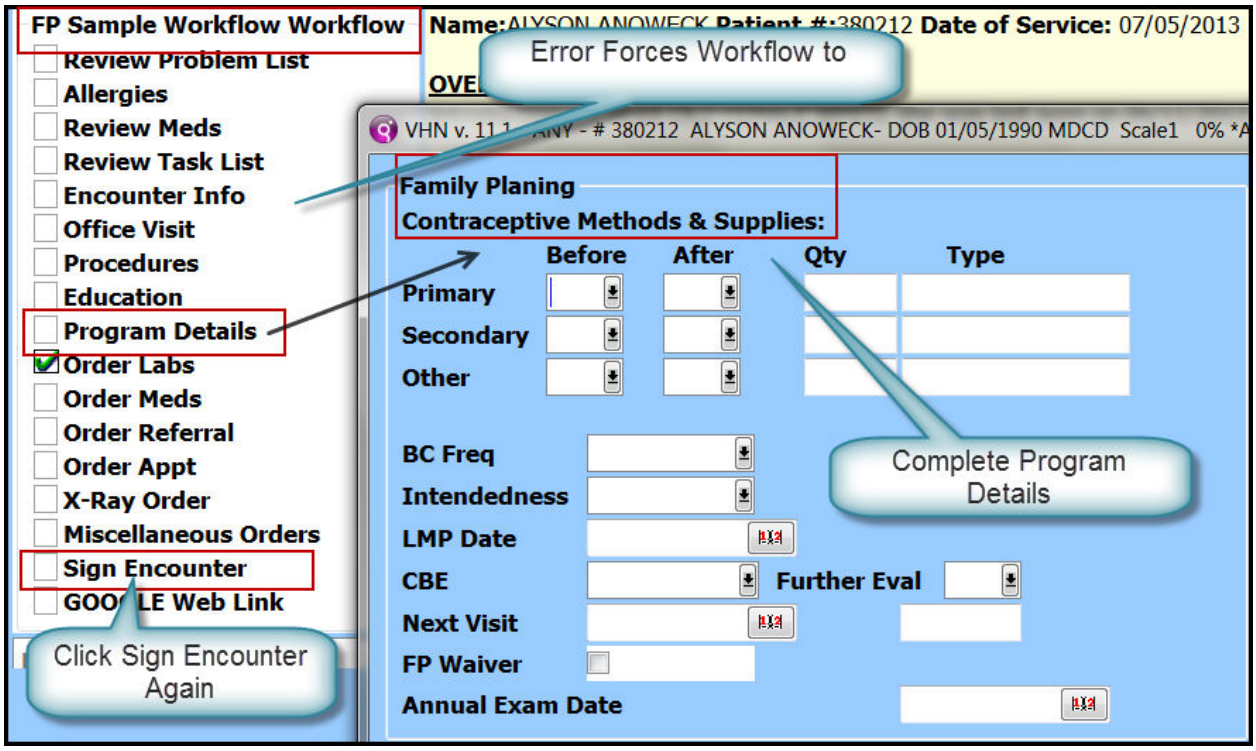
3. Problem List Review
4. Immunizations
5. Review Task List



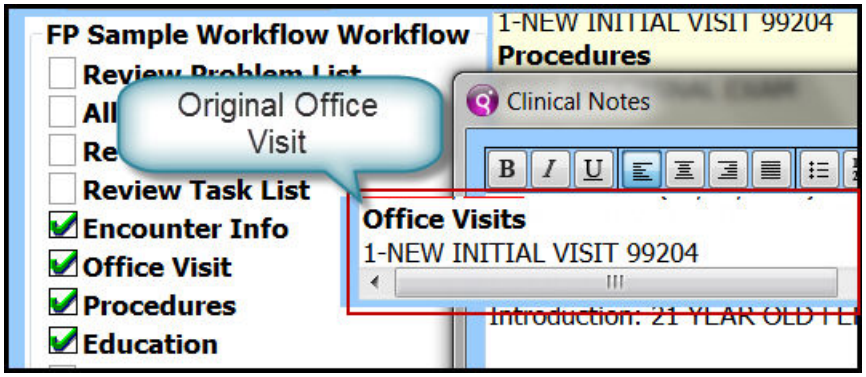
14. All Order Types
    1. Medication Orders
    2. Lab Orders
    3. Appointment Orders
    4. Referral Orders
    5. X-Ray Order
    6. Miscellaneous Orders
        1. New functionality
        2. Allows users to enter orders other than the above categories
        3. Order is free text
        4. Order can be repeated
        5. Mark the order completed when order is written
        6. Order will insert into the Task List to be assigned to another provider
15. Sign Encounter
    1. Takes user to Sign/Save of Encounter Note
        1. Sign the Note to close the encounter
        2. Use the Final Edit/Sign button
        3. Encounter edits completed when user clicks Sign/Save button
        4. System continues to generate messages regarding items not complete for the encounter
            1. Office visit
            2. Diagnosis
            3. Family Planning
                1. Procedures
                2. Education/Other Services
                3. Program Details
        5. If encounter is incomplete reopens the workflow

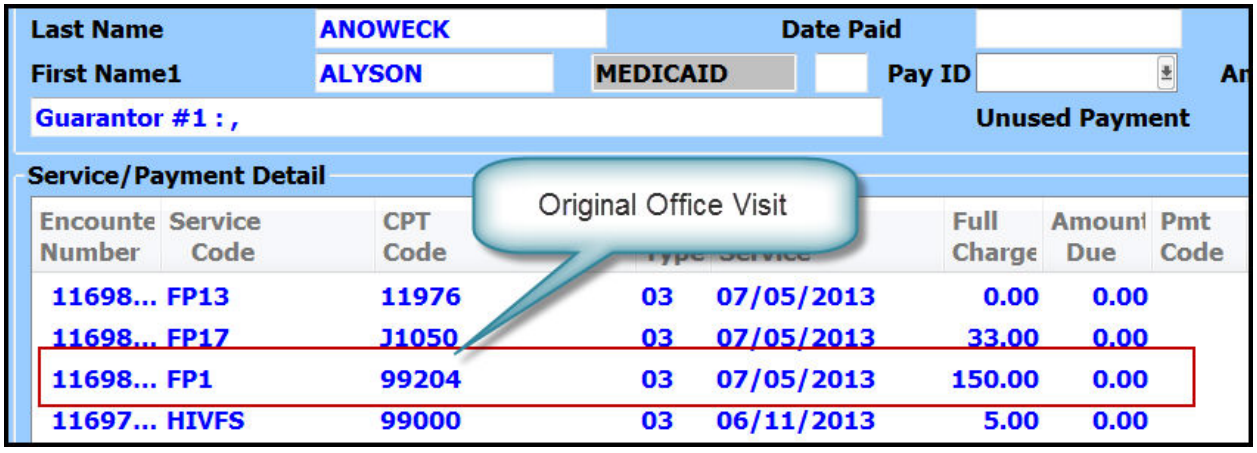

Hide Workflow
Encounter Note
Go To Construct Mode
Final Edit/Sign
FP Sample Workflow Workflow
Review Problem List
Allergies
Review Meds
Review Task List
Encounter Info
Office Visit
Procedures
Education
Program Details
Order Labs
Order Meds
Order Referral
Order Appt
X-Ray Order
Miscellaneous Orders
Sign Encounter
1-NEW INITIAL VISIT 99204
Procedures
Clinical Notes
Name:ARIANA ANIMASHAWN Patient #:380249 Date of Service
OVERVIEW
Introduction: 21 YEAR OLD FEMALE WHITE She was last seen on 0
SUBJECTIVE
Visit Type
VISIT TYPE: INITIAL MEDICAL EXAM
OBJECTIVE
Recent Lab Results
CHLA/CHLA-POSITIVE (07/05/2013)
PTSTFP/PTST-POSITIVE (07/05/2013)
Office Visits
1-NEW INITIAL VISIT 99204
Sign/Save
Cancel
Macros
Closes Encounter

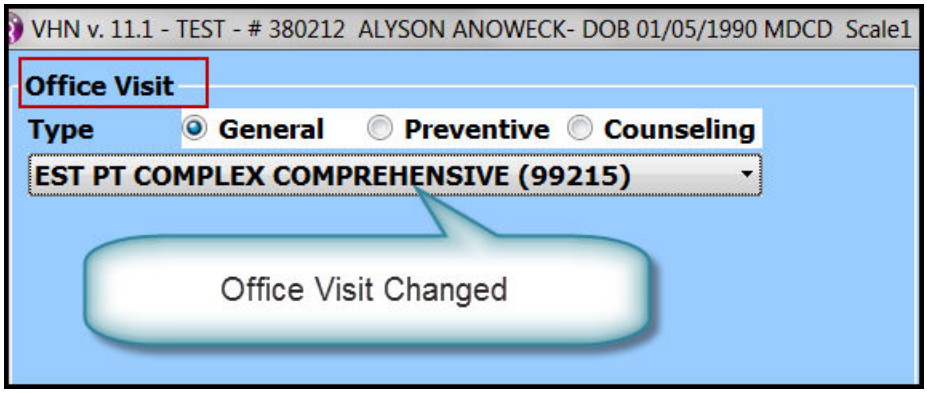

ERROR
Program Details screen must be completed before saving.
Error Message for Program Details

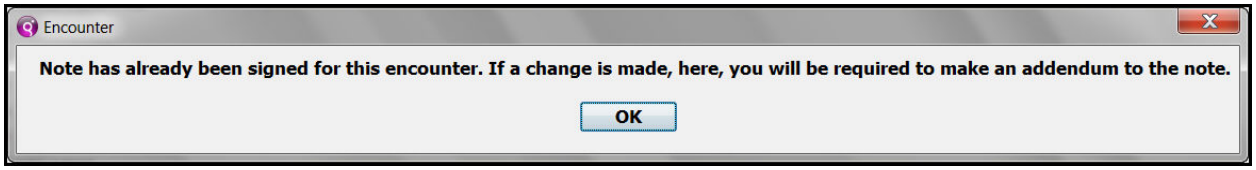

FP Sample Workflow Workflow
Review Problem List
Allergies
Review Meds
Review Task List
Encounter Info
Office Visit
Procedures
Education
Program Details
Order Labs
Order Meds
Order Referral
Order Appt
X-Ray Order
Miscellaneous Orders
Sign Encounter
Error Forces Workflow to
Family Planing
Contraceptive Methods & Supplies:
Before
After
Qty
Type
Primary
Secondary
Other
BC Freq
Intendedness
LMP Date
CBE
Further Eval
Next Visit
FP Waiver
Annual Exam Date
Complete Program Details
Click Sign Encounter Again

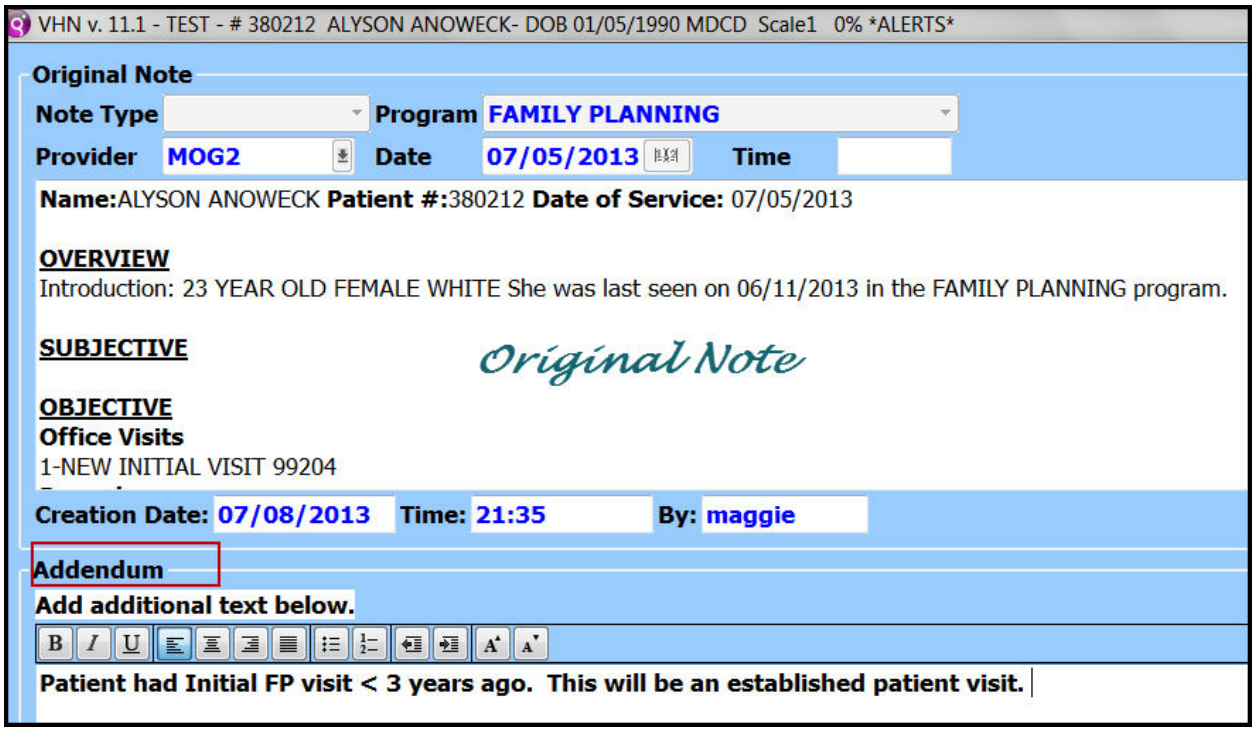
5. Changes to a signed/closed encounter
    1. Any changes to a field after the note is completed and signed require an addendum to the note
        1. Make the change
        2. Message displays that Addendum is required
        3. User taken to the Addendum portion of progress notes.
        4. Addendum attached to Encounter note automatically.
    2. Modifies the billing for this patient visit even for a closed encounter

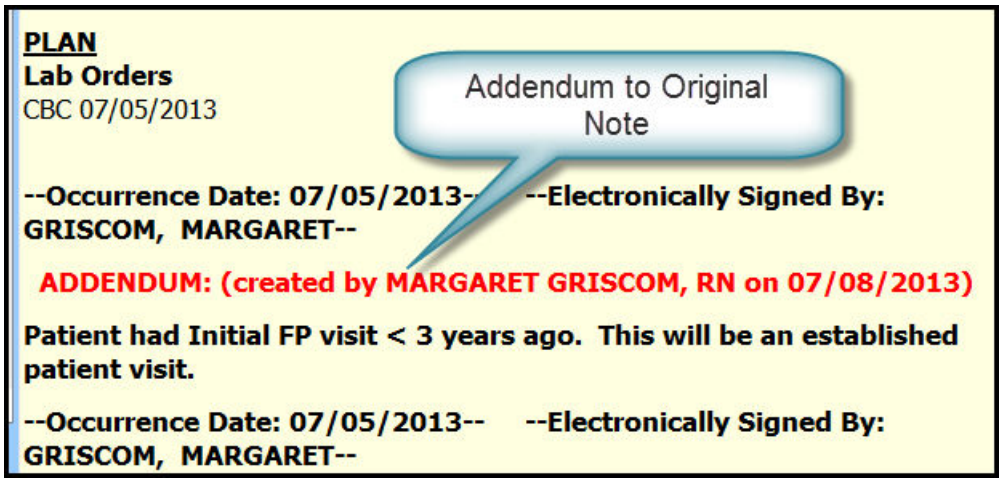


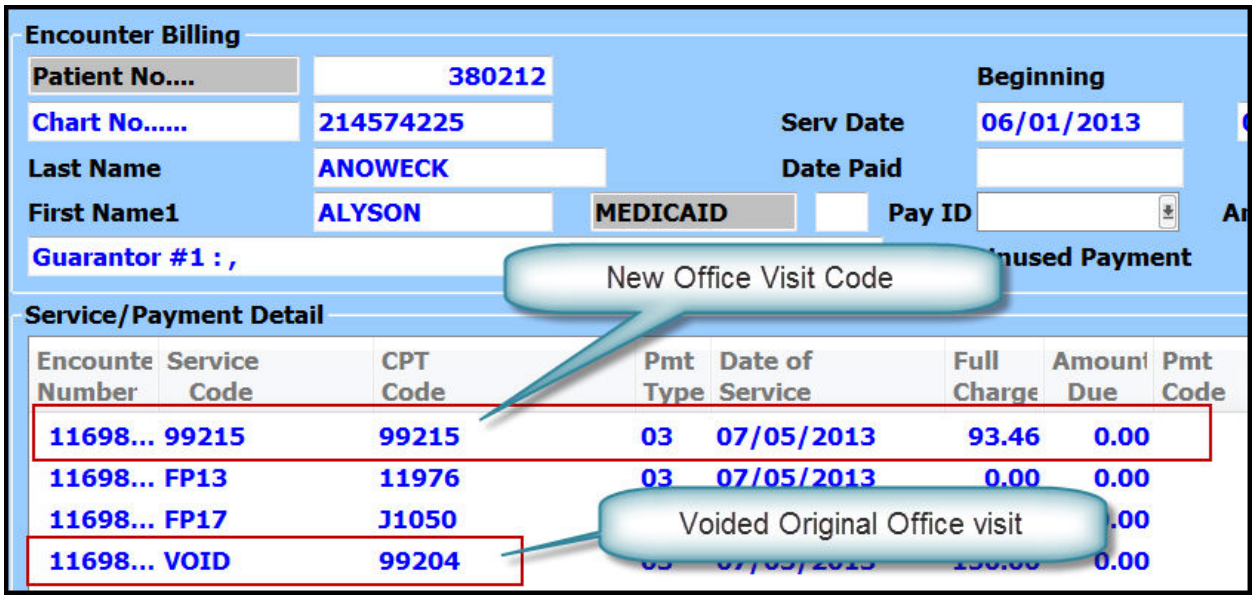




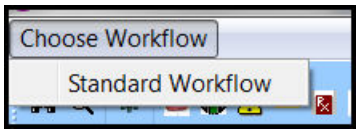

Encounter
Note has already been signed for this encounter. If a change is made, here, you will be required to make an addendum to the note.
OK


VHN v. 11.1 - TEST - # 380212 ALYSON ANOWECK- DOB 01/05/1990 MDCD Scale1 0% *ALERTS*
Original Note
Note Type
Program FAMILY PLANNING
Provider MOG2
Date 07/05/2013
Time
Name:ALYSON ANOWECK Patient #:380212 Date of Service: 07/05/2013
OVERVIEW
Introduction: 23 YEAR OLD FEMALE WHITE She was last seen on 06/11/2013 in the FAMILY PLANNING program.
SUBJECTIVE
Original Note
OBJECTIVE
Office Visits
1-NEW INITIAL VISIT 99204
Creation Date: 07/08/2013 Time: 21:35 By: maggie
Addendum
Add additional text below.
Patient had Initial FP visit < 3 years ago. This will be an established patient visit.


PLAN
Lab Orders
CBC 07/05/2013
Addendum to Original Note
--Occurrence Date: 07/05/2013-- --Electronically Signed By: GRISCOM, MARGARET--
ADDENDUM: (created by MARGARET GRISCOM, RN on 07/08/2013)
Patient had Initial FP visit < 3 years ago. This will be an established patient visit.
--Occurrence Date: 07/05/2013-- --Electronically Signed By: GRISCOM, MARGARET--



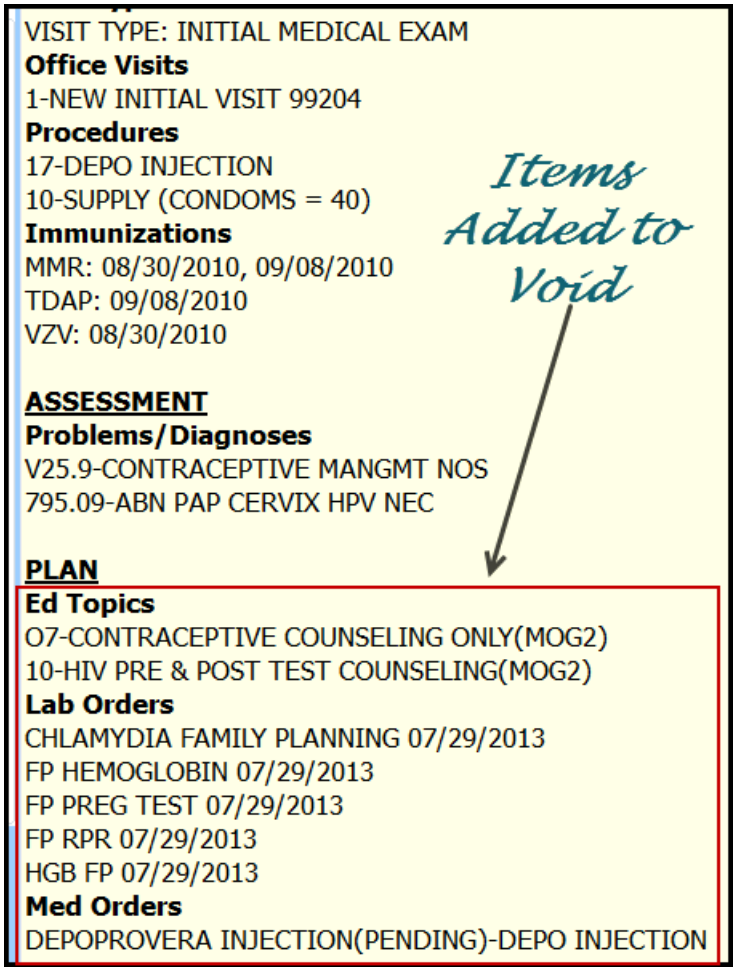
6. Default Workflow
    1. Provides a workflow for users that have not previously set-up workflows
    2. Provides access to all required areas of the encounter.
    3. Users are encouraged to create their own encounters for their EHR



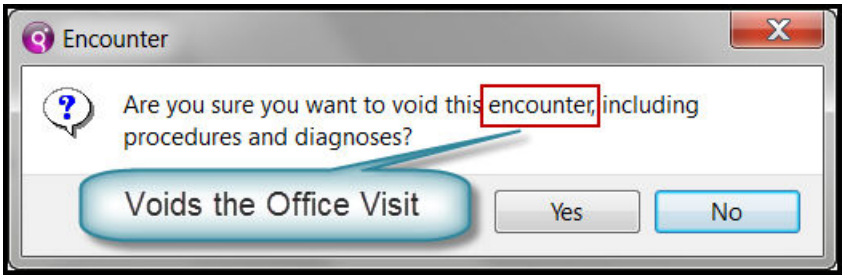
7. Voiding an Encounter
    1. Select the Void icon from the toolbar
    2. Enter password
    3. Message: Are you sure you want to void the Encounter? This voids:
        1. Office Visit
        2. Diagnosis
        3. Procedures
    4. Charting Forms (e-charts)
        1. Signed forms must be voided through e-chart
        2. If form not signed Cancel form prior to voiding encounter
    5. Encounter Notes
        1. If signed must be voided by person designated to Void Progress Notes
        2. If not signed void when encounter is voided
    6. New items voided
        1. Labs Not collected:
            1. Cancel Labs ordered for this Encounter
            2. Answer Yes or No
        2. Labs Collected
            1. Message: Cannot void encounter due to collected labs

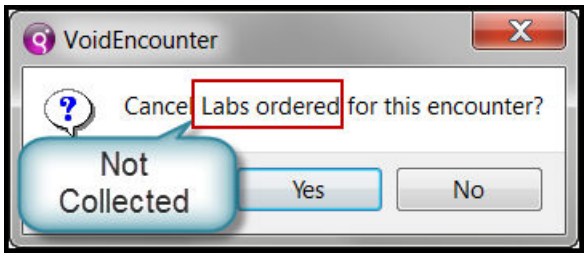
2. Go to lab orders and cancel the lab that has been collected
3. Click Void icon on the encounter toolbar to repeat steps

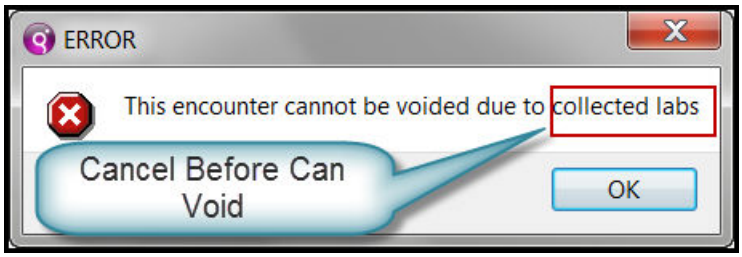
3. Medication Orders:
    1. Pending Med orders exist for this encounter. Do you want to void them now?
    2. For medications dispensed go to the Pharmacy Dispensing screen to void
4. Educational topics



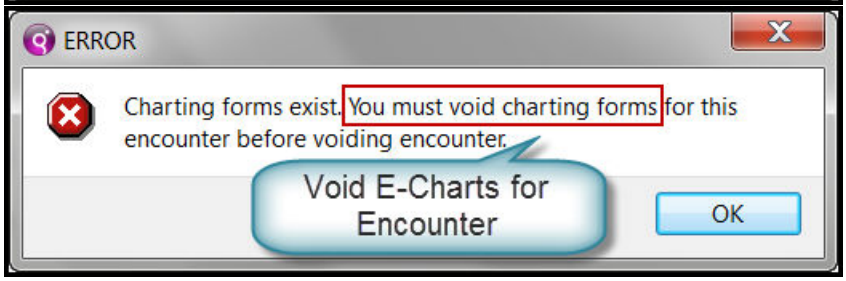
Possible Messages:

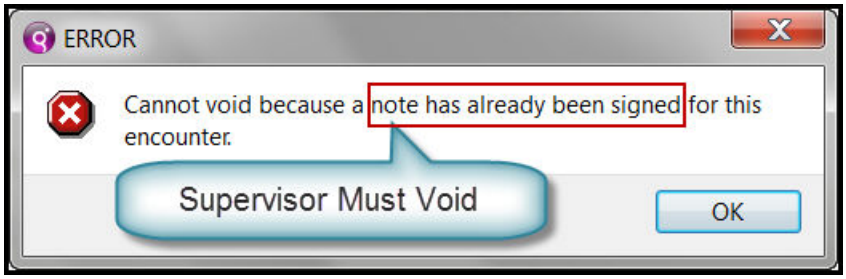

Encounter
Are you sure you want to void this encounter, including procedures and diagnoses?
Voids the Office Visit
Yes
No

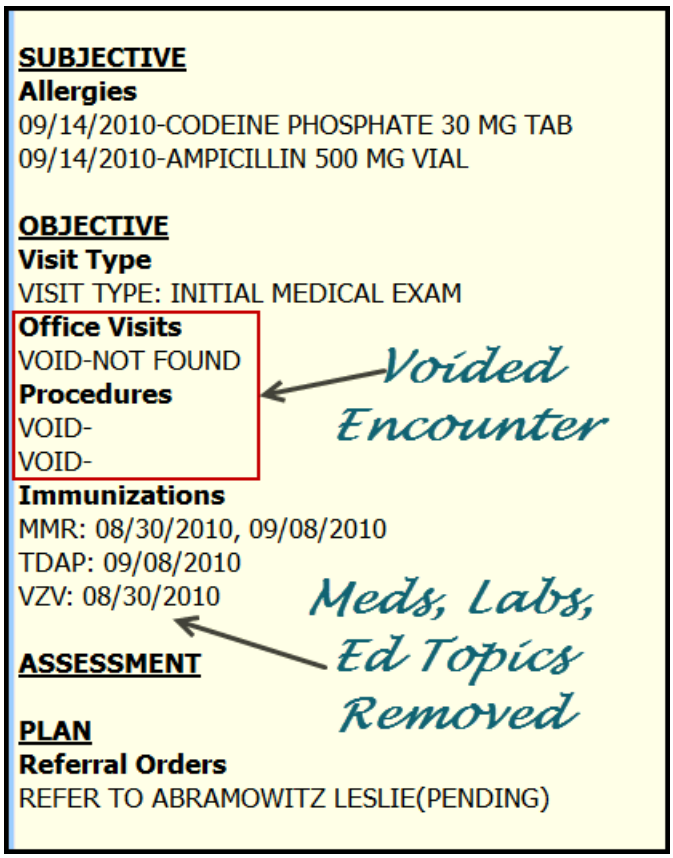

VoidEncounter
Cancel Labs ordered for this encounter?
Not Collected
Yes
No


ERROR
This encounter cannot be voided due to collected labs
Cancel Before Can Void
OK

Encounter
Only Pending Meds Void
Pending Med orders exist for this encounter. Do you want to void them now?
Yes
No

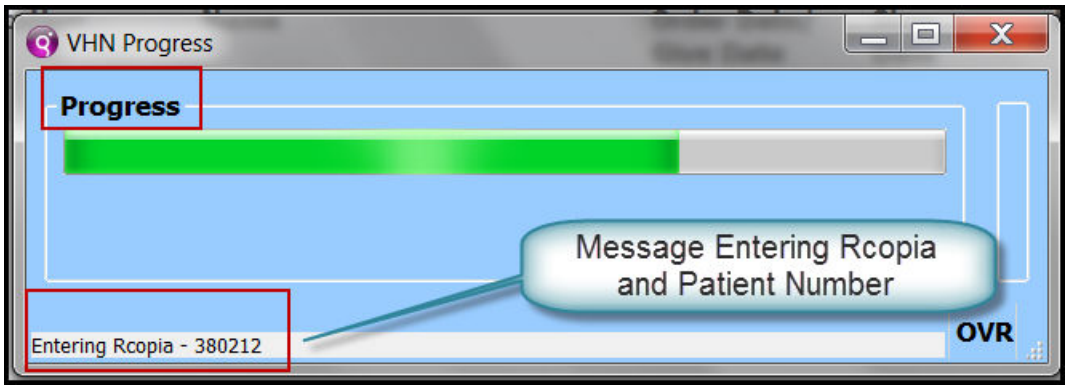

ERROR
Charting forms exist. You must void charting forms for this encounter before voiding encounter.
Void E-Charts for Encounter
OK


ERROR
Cannot void because a note has already been signed for this encounter.
Supervisor Must Void
OK


SUBJECTIVE
Allergies
09/14/2010-CODEINE PHOSPHATE 30 MG TAB
09/14/2010-AMPICILLIN 500 MG VIAL
OBJECTIVE
Visit Type
VISIT TYPE: INITIAL MEDICAL EXAM
Office Visits
VOID-NOT FOUND
Procedures
VOID-
VOID-
Voided Encounter
Immunizations
MMR: 08/30/2010, 09/08/2010
TDAP: 09/08/2010
VZV: 08/30/2010
Meds, Labs, Ed Topics Removed
ASSESSMENT
PLAN
Referral Orders
REFER TO ABRAMOWITZ LESLIE(PENDING)

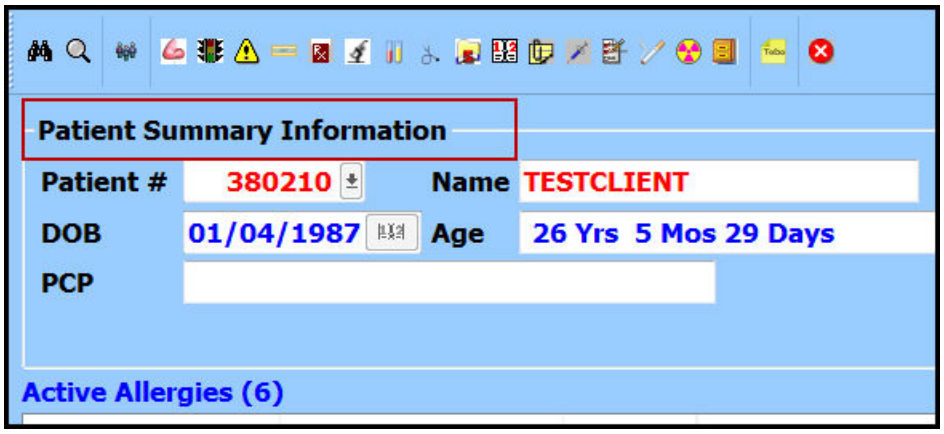
E-Prescribing

1. E-Prescribing Messages
    1. Message boxes for e-prescribing replaced by a Progress Bar
        1. Message no longer display in a message window
        2. Progress is noted by a Progress Bar similar to the Dictionary Progress on login

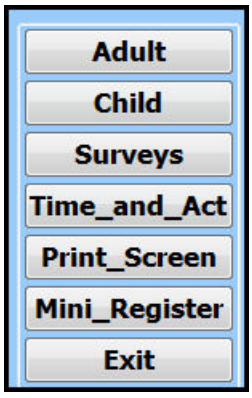


Patient Summary Screen

1. Added word Summary to the Patient Summary Screen
    1. Avoid confusion with the Encounter
    2. Provide clarity of screen purpose

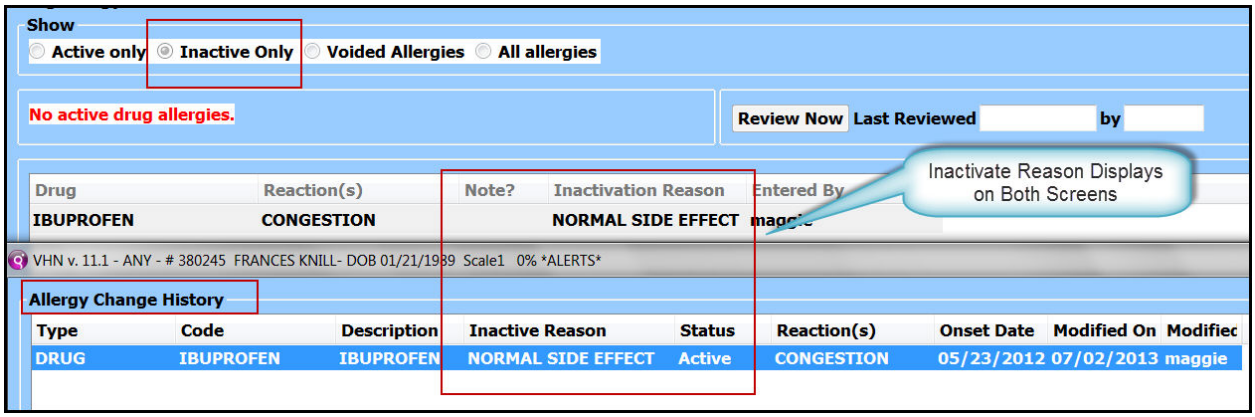


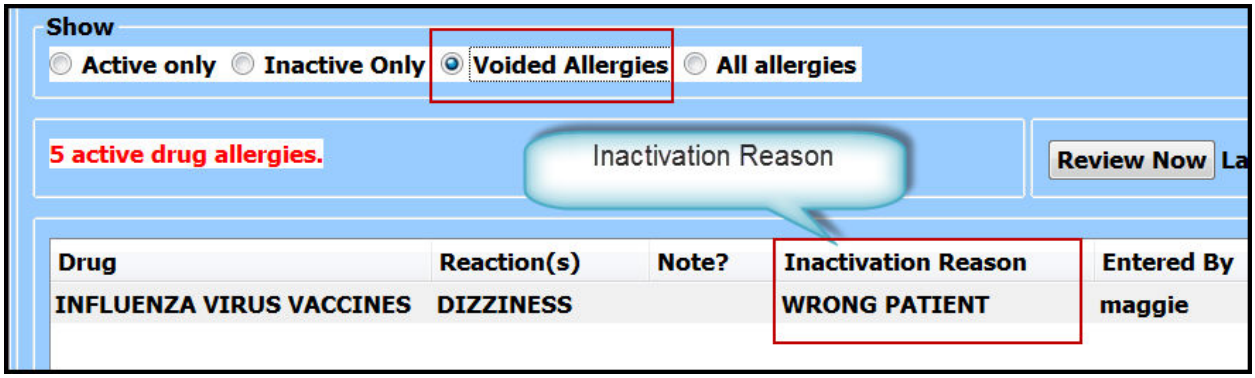
2. Menu Buttons
    1. Toolbar icons have replaced menu buttons for all except sub menus
    2. User must use the icons for access to stand alone screens and processes
    3. Buttons that connect to other menus will continue for this release



Allergies

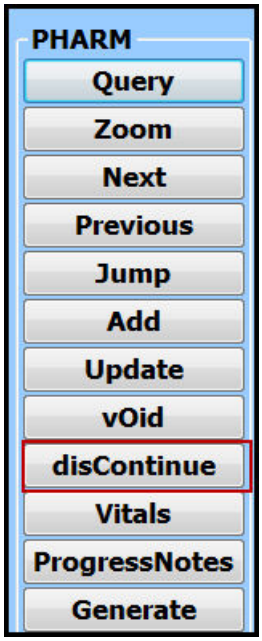
1. Inactivated or Voided allergies
    1. Reason for inactivating an allergy now displays in the history screen
        1. Select the option to view
            1. Select any of the items except Voided allergies
            2. Click History
            3. Inactive reason displays
        2. Voided allergies
            1. Only display on Voided Allergies option
            2. Reason for void displays on the same screen
            3. No need to access history

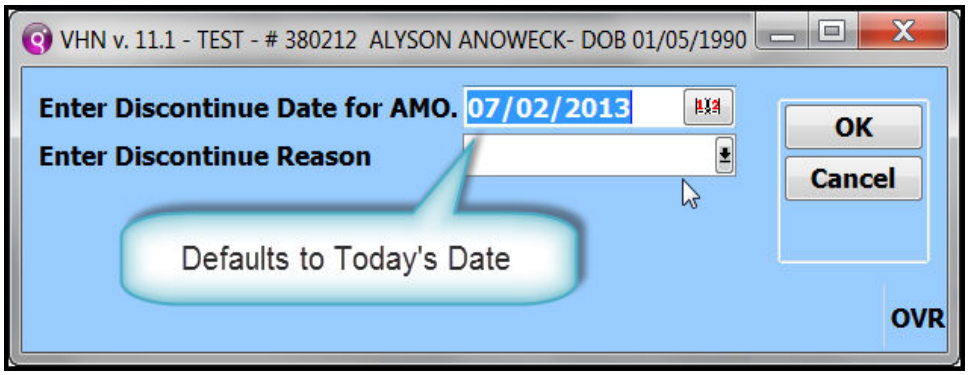


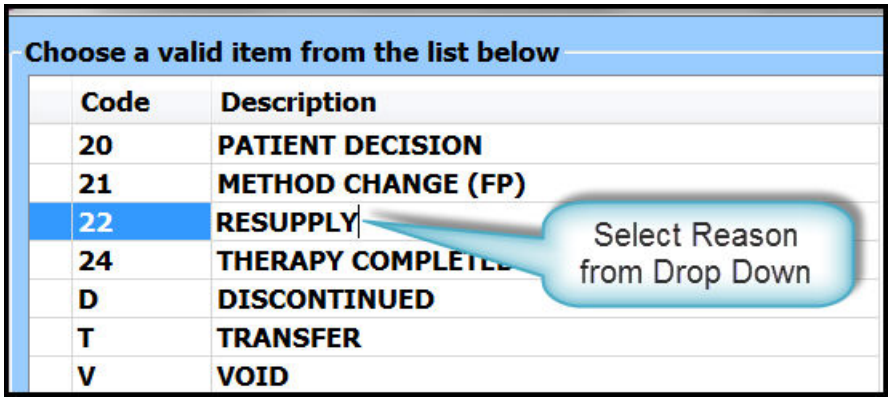


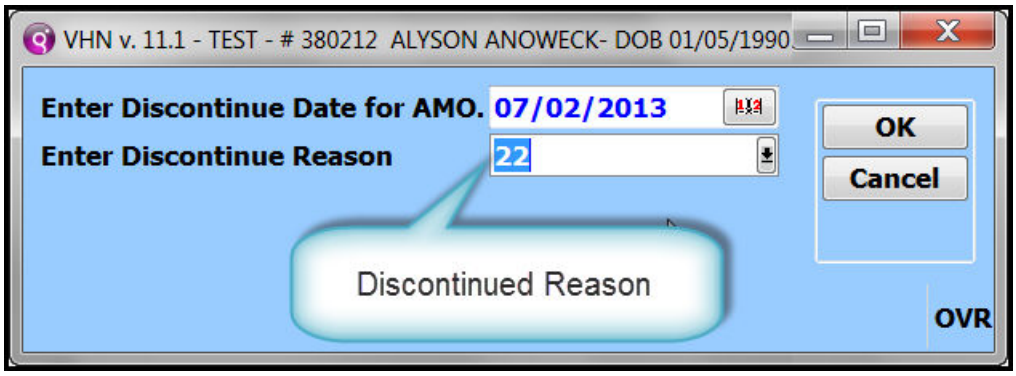
Discontinue Medications

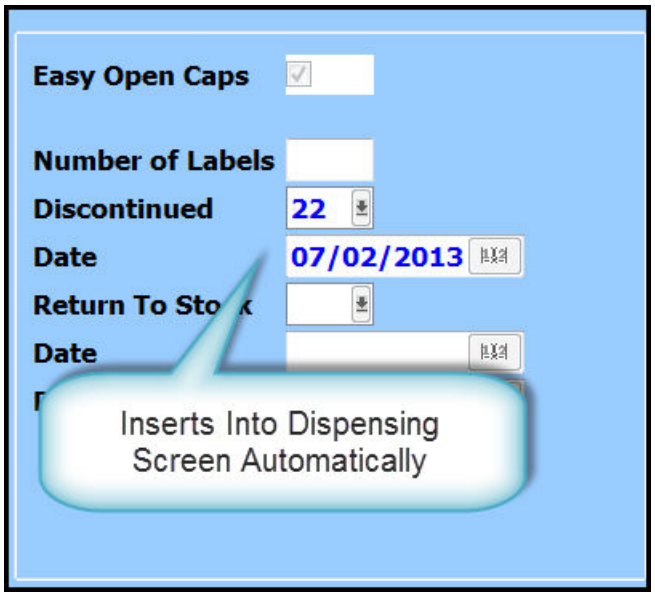
1. Medications discontinued from the dispensing screen
    1. Button added to menu
        1. Screen displays with today's date
        2. Enter discontinue reason from the drop down
        3. Inserts discontinued date and reason
            1. In Dispensing screen
            2. On medication history screen
            3. Medication moves to Complete History from the Active Medications display.

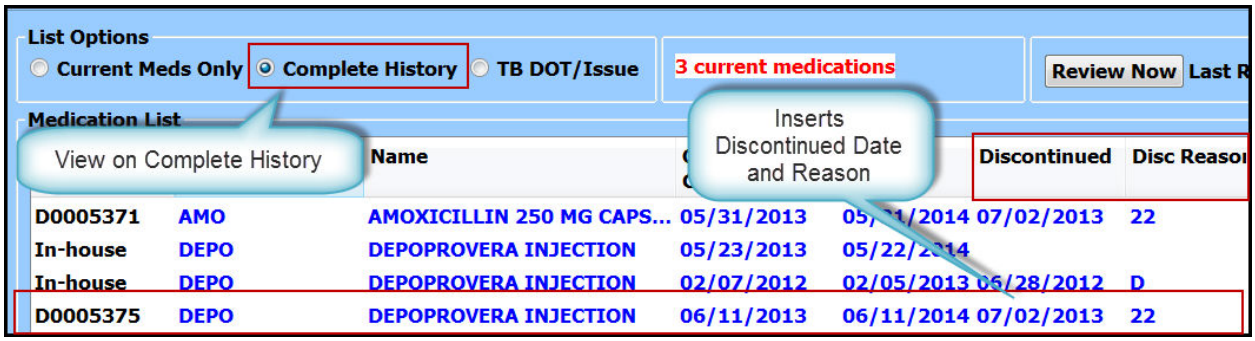






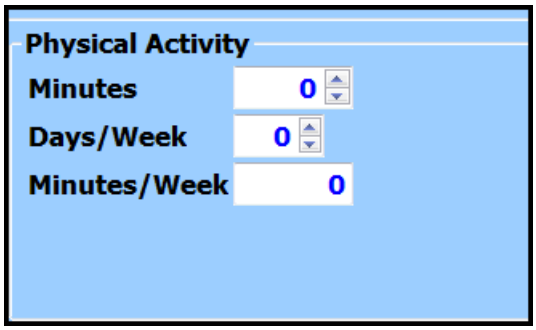

VHN v. 11.1 - TEST - # 380212 ALYSON ANOWECK- DOB 01/05/1990
Enter Discontinue Date for AMO. 07/02/2013
Enter Discontinue Reason 22
OK
Cancel
Discontinued Reason
OVR

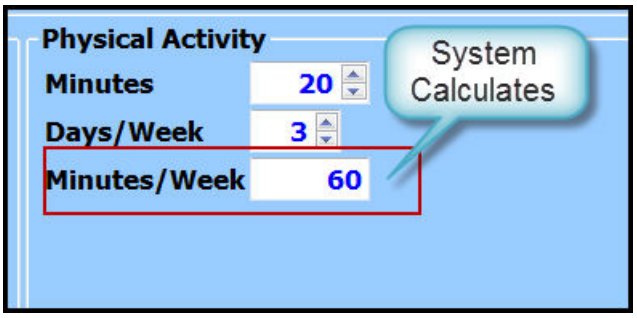

Easy Open Caps
Number of Labels
Discontinued 22
Date 07/02/2013
Return To Sto
Date
Inserts Into Dispensing Screen Automatically

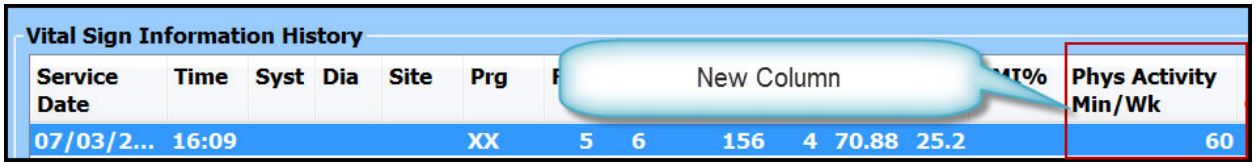

List Options
Current Meds Only
Complete History
TB DOT/Issue
3 current medications
Review Now
Last R
Medication List
View on Complete History
Inserts Discontinued Date and Reason
Name
Discontinued
Disc Reaso
D0005371 AMO AMOXICILLIN 250 MG CAPS... 05/31/2013 05/31/2014 07/02/2013 22
In-house DEPO DEPOPROVERA INJECTION 05/23/2013 05/22/2014
In-house DEPO DEPOPROVERA INJECTION 02/07/2012 02/05/2013 06/28/2012 D
D0005375 DEPO DEPOPROVERA INJECTION 06/11/2013 06/11/2014 07/02/2013 22

Vital Signs

1. Added physical activity information to Vital Signs
    1. Access vital signs screen
    2. Add
    3. New fields
        1. Minutes: number of minutes per day patient exercises
        2. Days/Week: the number of days a week the patient exercises
        3. Minutes/Week: calculated by the system
            1. Tab out of the Days/Week
            2. System calculates minutes per week
        4. Total minutes per week inserts into Vital Signs Summary History

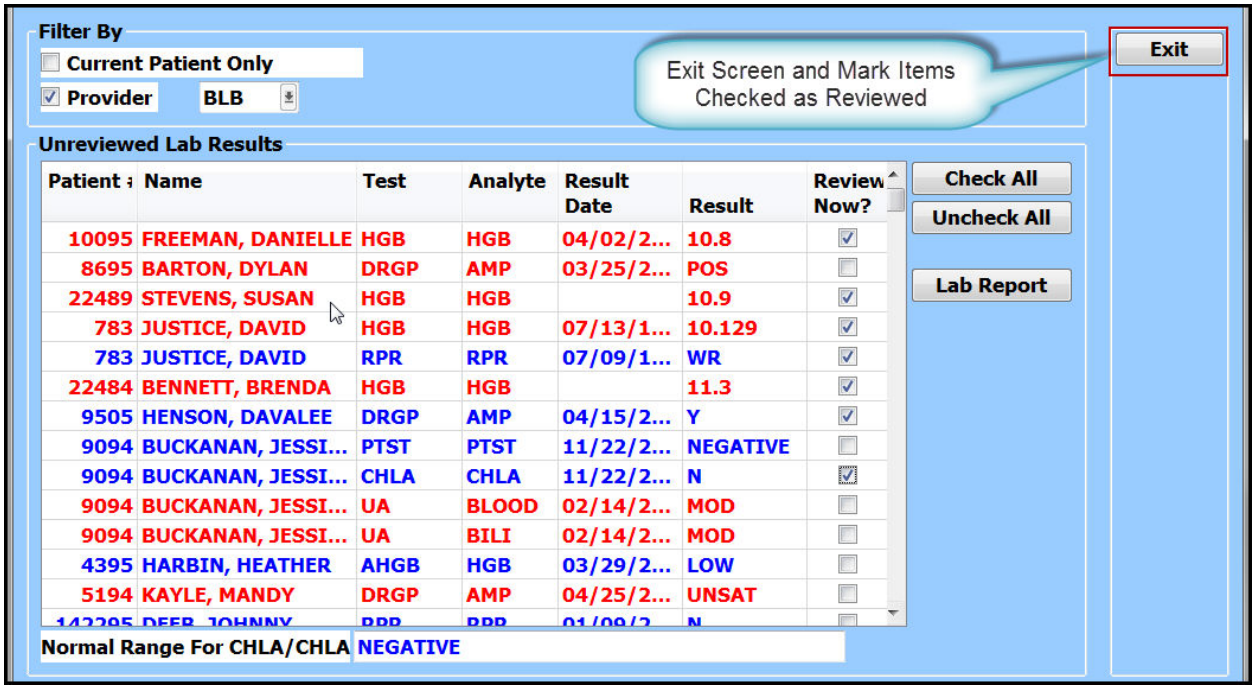




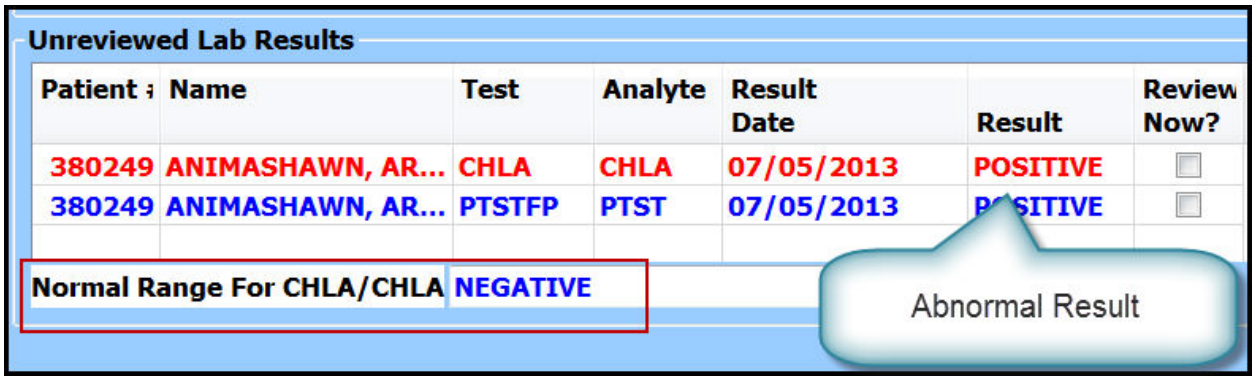


Lab Review

1. Exit item on lab review screen
    1. User accesses lab review from the tool bar on the clinical summary screen.
        1. Sort by either current client or by probider
        2. Check items reviewed
            1. Check individually
            2. Use the check all feature
        3. Exit:
            1. User leaves the screen
            2. Items reviewed are removed from the screen and marked reviewed.

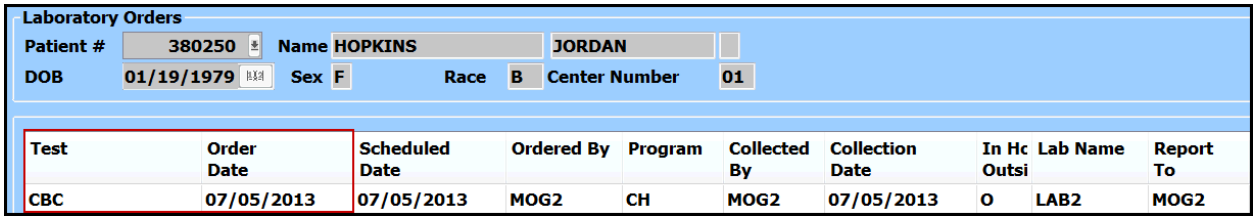

Filter By
Current Patient Only
Provider
BLB
Exit Screen and Mark Items Checked as Reviewed
Exit
Unreviewed Lab Results
Patient #
Name
Test
Analyte
Result Date
Result
Review Now?
Check All
Uncheck All
Lab Report
10095 FREEMAN, DANIELLE HGB HGB 04/02/2... 10.8
8695 BARTON, DYLAN DRGP AMP 03/25/2... POS
22489 STEVENS, SUSAN HGB HGB 10.9
783 JUSTICE, DAVID HGB HGB 07/13/1... 10.129
783 JUSTICE, DAVID RPR RPR 07/09/1... WR
22484 BENNETT, BRENDA HGB HGB 11.3
9505 HENSON, DAVALEE DRGP AMP 04/15/2... Y
9094 BUCKANAN, JESSI... PTST PTST 11/22/2... NEGATIVE
9094 BUCKANAN, JESSI... CHLA CHLA 11/22/2... N
9094 BUCKANAN, JESSI... UA BLOOD 02/14/2... MOD
9094 BUCKANAN, JESSI... UA BILI 02/14/2... MOD
4395 HARBIN, HEATHER AHGB HGB 03/29/2... LOW
5194 KAYLE, MANDY DRGP AMP 04/25/2... UNSAT
Normal Range For CHLA/CHLA
NEGATIVE

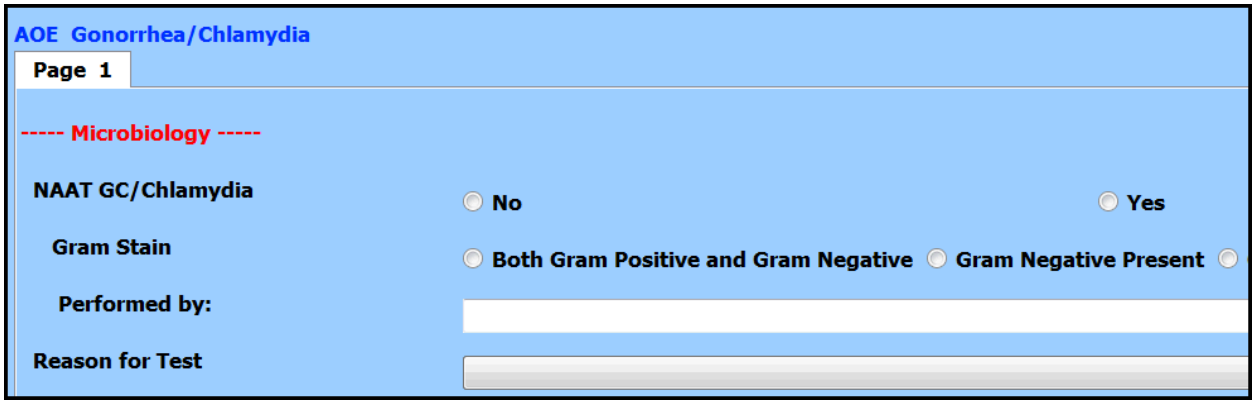
2. Abnormal results display in red
    1. Normals must be set-up in lab maintenance screen
        1. If numeric results are based on the normal High and Low in the lab set-up
        2. Positive results will be considered abnormal
        3. If the result includes "UNSAT" then considered abnormal
        4. Pregnancy always displays in blue as no true abnormal
    2. Click in the result and the Normal Range displays at the bottom of the screen



3. Special forms to be sent with specimens
    1. System can generate a special form if needed to be sent with a speciment
    2. Form generates from an e-chart
    3. Order lab that requires the special form
        1. Order from lab orders
        2. Order from clinical encounter/lab orders
        3. Click OK
    4. Required e-chart displays
        1. Complete and sign the e-chart
            2. Click Finish to return to clinical encounter or to the lab orders

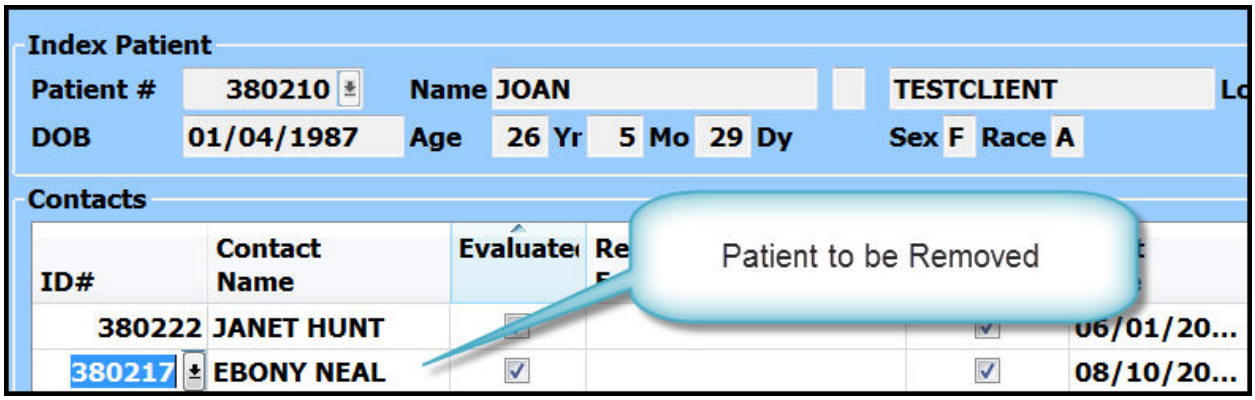
See System Administration notes for set-up

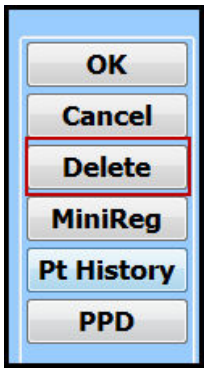




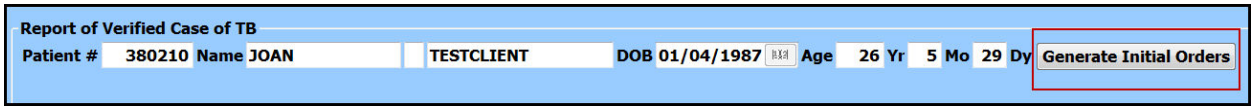
TB Screens

1. Delete button added to the TB Contacts screen
    1. Access the TB Contacts screen
    2. Update
    3. Select contact to be deleted
    4. Click the Delete button
    5. Patient will be removed from the contact screen

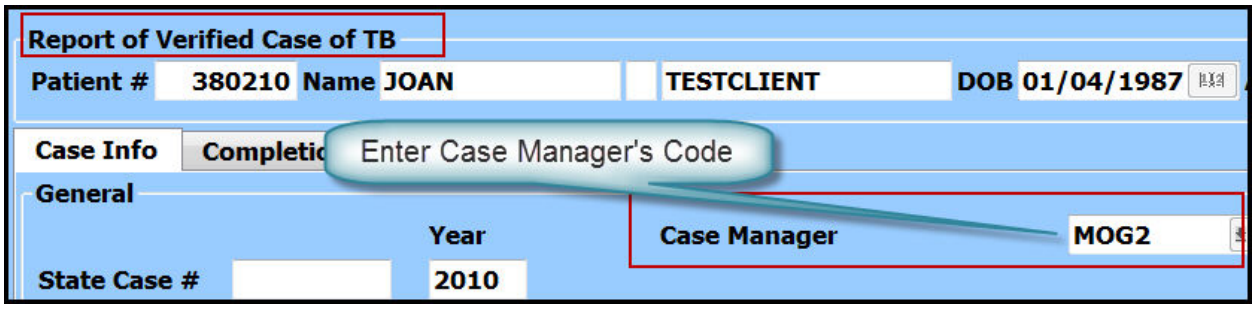

Index Patient
Patient # 380210 Name JOAN TESTCLIENT
DOB 01/04/1987 Age 26 Yr 5 Mo 29 Dy Sex F Race A
Contacts
ID# Contact Name
380222 JANET HUNT 06/01/20...
380217 EBONY NEAL 08/10/20...
Patient to be Removed



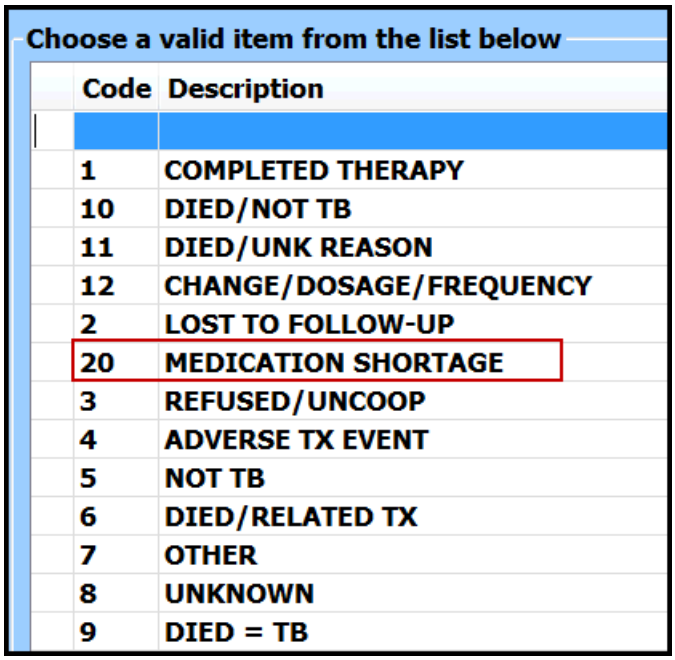
2. Generate Initial Orders
    1. Allow users to establish order set for initial TB orders if desired
        1. Click on Initial Orders
            1. An order set for TB orders will display
            2. Order set must be named TBINIT to display

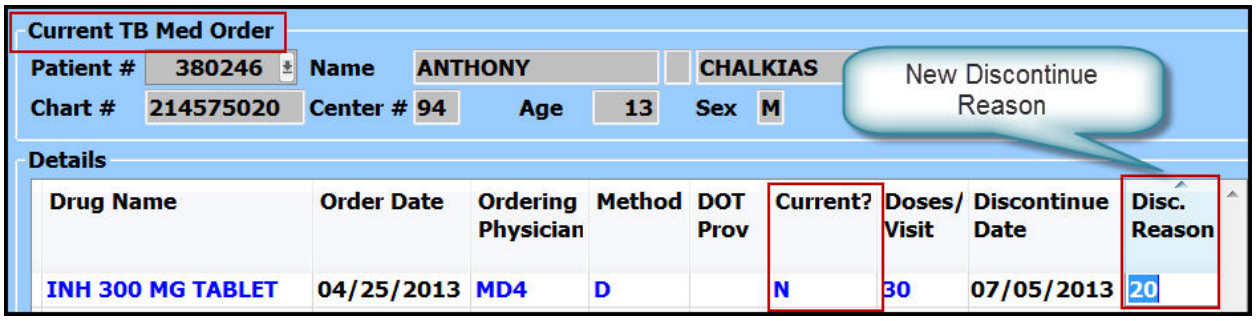

Report of Verified Case of TB
Patient # 380210 Name JOAN TESTCLIENT DOB 01/04/1987 Age 26 Yr 5 Mo 29 Dy
Generate Initial Orders

3. Case manager
    1. Field added to Case report for Case Manager
        1. Optional field
        2. Enter case managers provider code



4. Medication Shortage
    1. New code added to Discontinue Reason
    2. Allows to discontinue a TB medication due to a shortage of a specific medication
    3. Access Current TB Meds
        1. Change Current? to N
        2. Enter Discontinue Reason 20
        3. OK

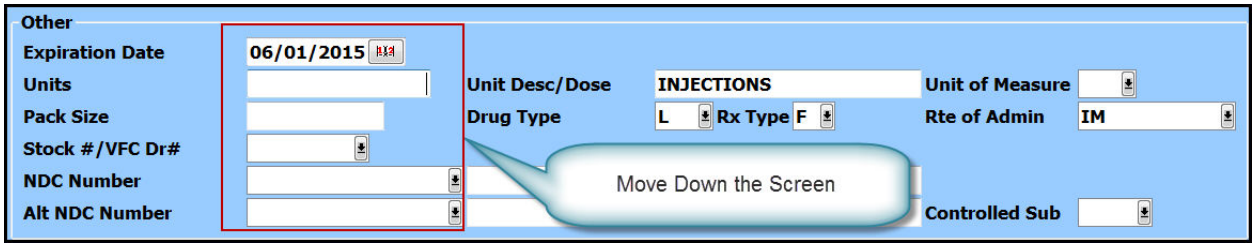




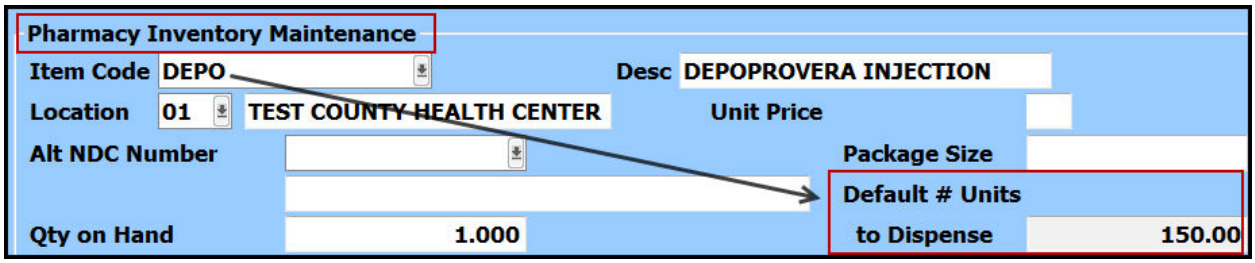
System Administrators need to set code in the Valid Codes table

Pharmacy Screens

1. Pharmacy Transaction Screen flow modified
    1. Changes to the pharmacy transaction screen allow improved alignment of fields
        1. Changes focused on the "Other" section
        2. Users move down the screen instead of down-across and then back down again
        3. No longer tab through fields that are already populated
        4. Easily follow data entry as move through the screen

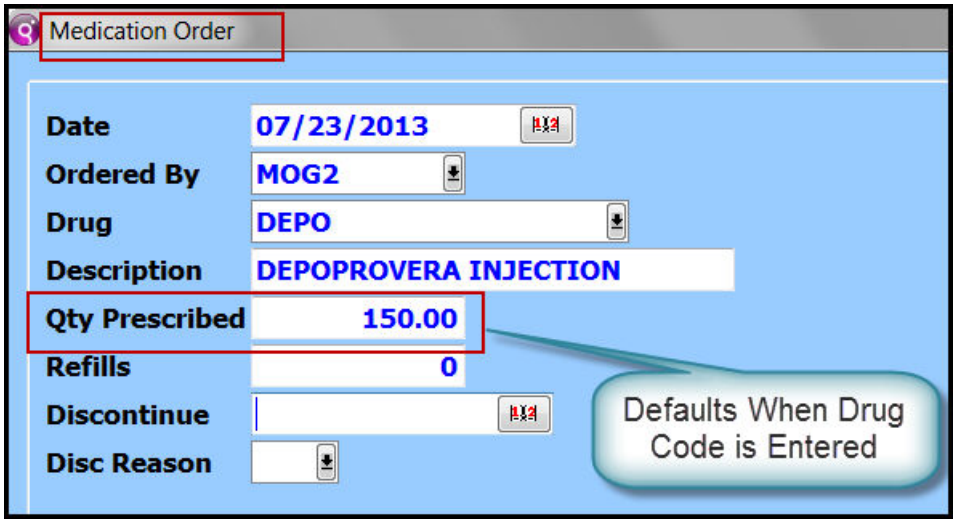


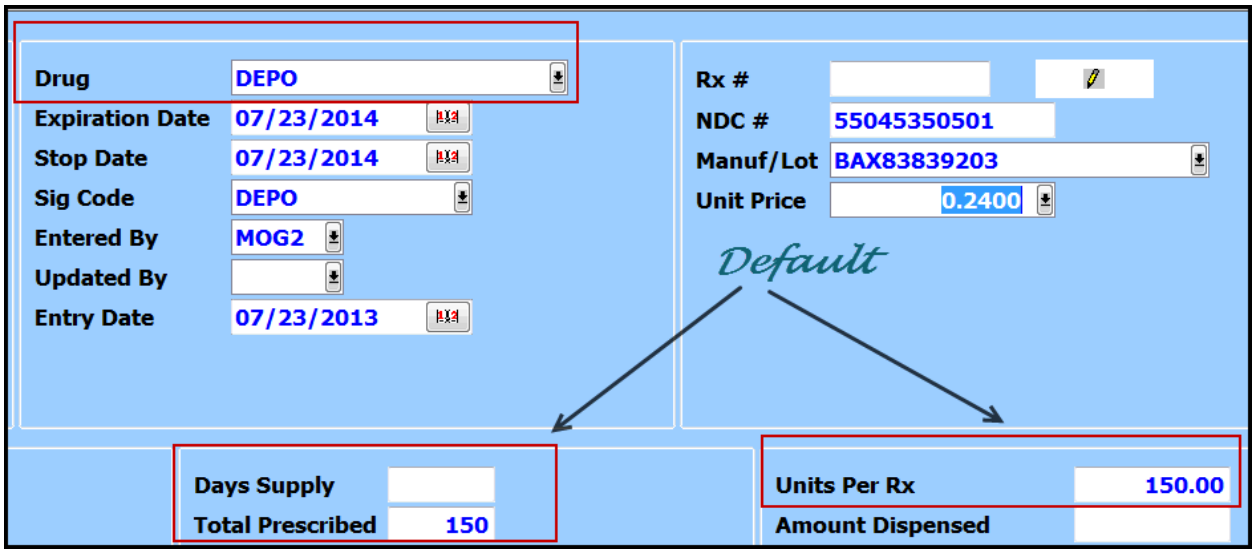
2. Default Number of Units to Dispense
    1. Used for Depo Provera
    2. Pharmacy Inventory Screen
        1. Reflects the number of units that are routinely given of the medication
        2. Update the Pharmacy Inventory Screen
            1. Enter the 150 in the Default Number of Units
            2. Takes numeric values only



    3. Inhouse medication order
        1. 2 step order
            1. No refills
                1. Choose Order Meds from the Work Flow
                2. Enter the order
                    1. The number of units defaults on the order screen
                    2. Complete the order process
                3. Dispensing screen
                    1. Amount defaults into:
                        1. Total Prescribed field
                        2. Units per RX field

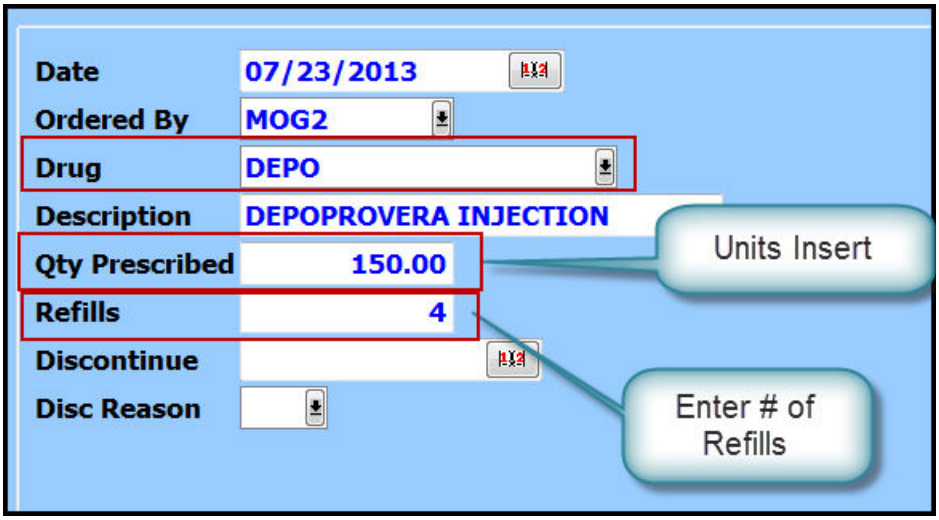
2. Tab to the Amount Dispensed and the units inserts automatically

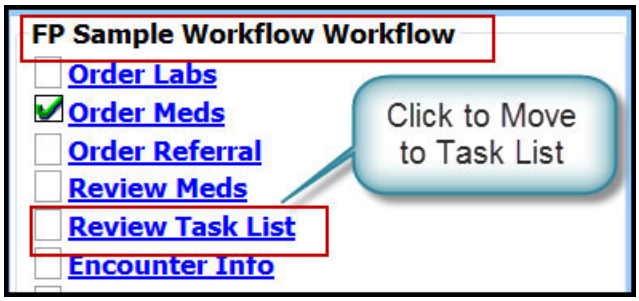




2. With Refills
    1. Orders
        1. Enter the Refills on the Medication Order
        2. Complete order
        3. Dispense Now? is No
    2. Click on the Task List in the Work Flow
        1. Select the Meds Tab
        2. Check the View/Process Order box on the Medication Order to move to the Dispensing Screen
    3. Process Order
        1. Enter the Dispensing Screen

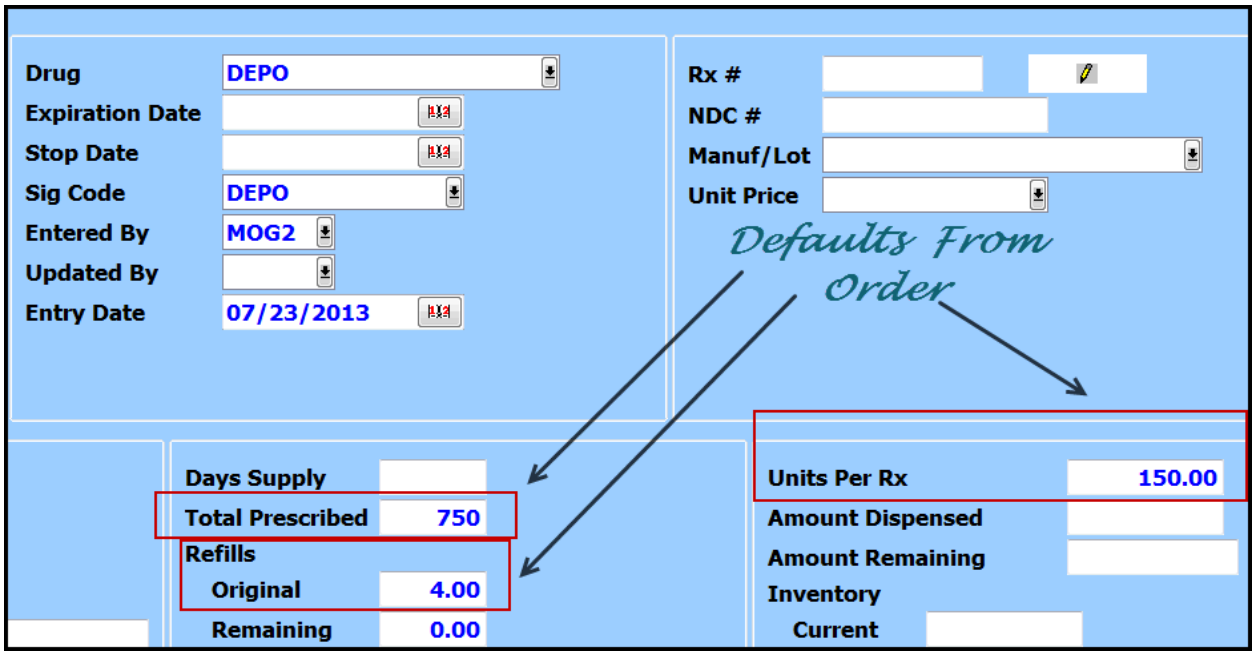
2. Defaults
    1. Total Prescribed:
        1. The number of refills Xs the number of refills
        2. System calculated
    2. Original # of Refills: Defaults from the order
    3. Remaining: Always 0 when enter the screen
    4. Units per RX: number of units from the Default # of Units for Dispensing on the Inventory Record
3. Tab to the Amount Dispensed
    1. Enter the number of Units to dispense
    2. Total Prescribed is unchanged
    3. Original # of Refills is unchanged
    4. Remaining (refills) :
        1. Same as Original # for initial order
        2. Decreases as refills entered
    5. Amount remaining is now the Total Prescribed minus the Amount Dispensed

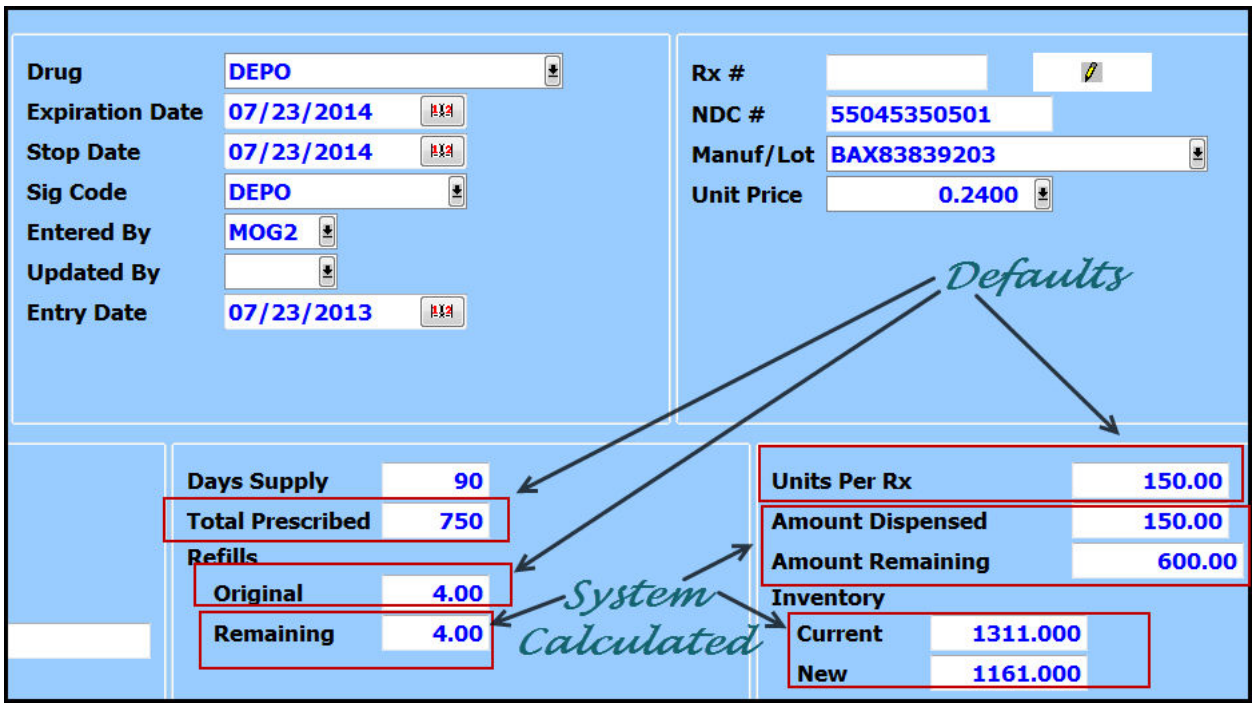




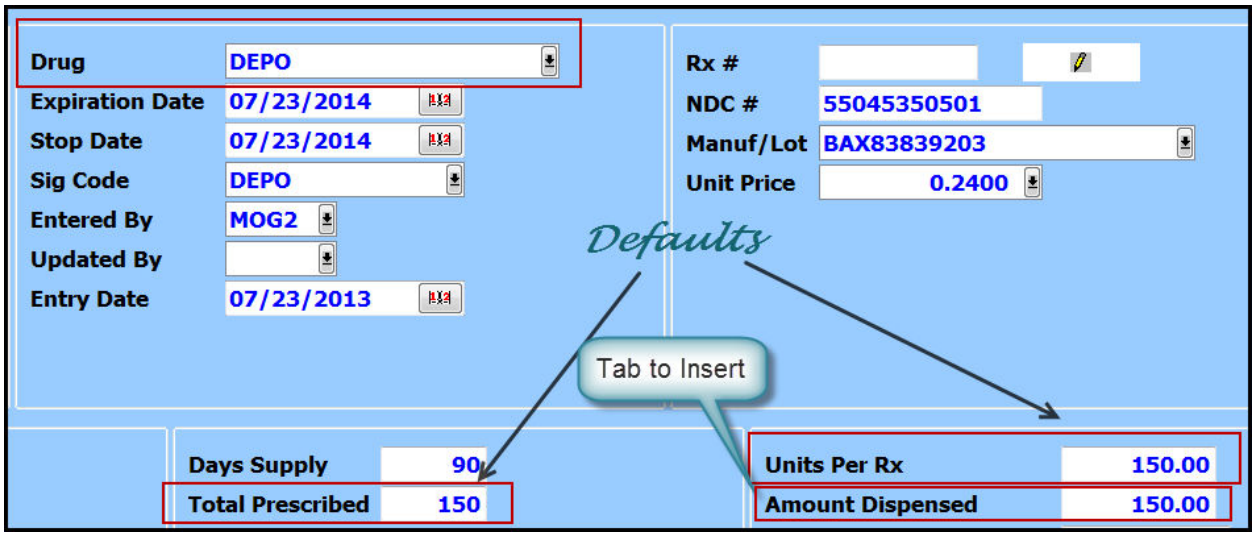
Select
Meds
Radiology

Orders
Task List Orders
Check
Description
Order Date
Due Date
Orderec
Owner
Status
View/Process Now
Reassign
Cancel
DEPO
07/23/2...
07/23/2...
MOG2
MOG2
PENDING


Drug
DEPO
Expiration Date
Stop Date
Sig Code
DEPO
Entered By
MOG2
Updated By
Entry Date
07/23/2013
Rx #
NDC #
Manuf/Lot
Unit Price
Defaults From Order
Days Supply
Total Prescribed
750
Refills
Original
4.00
Remaining
0.00
Units Per Rx
150.00
Amount Dispensed
Amount Remaining
Inventory
Current



2. 1 Step Drug Order (Georgia)
    1. Choose Order Meds from the Work Flow
    2. Dispensing screen displays
    3. Enter the Drug and Tab
        1. Units insert automatically in:
            1. Total Prescribed
            2. Units Per RX
        2. Tab to insert the units in the Amount Dispensed



Front Office

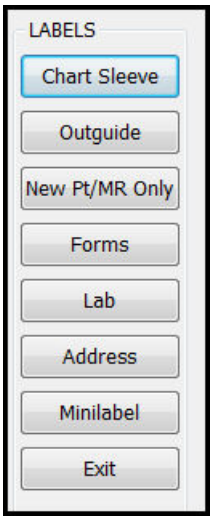
Front Office /Clerical

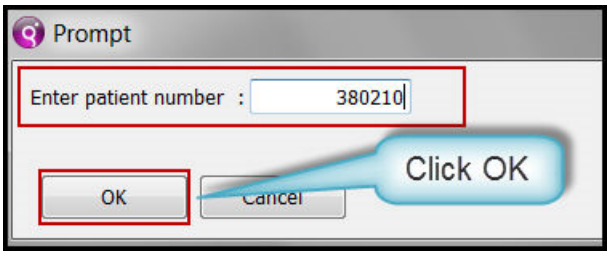
1. Patient labels

    1. Patient labels have been modified to be accessible from the Dashboard

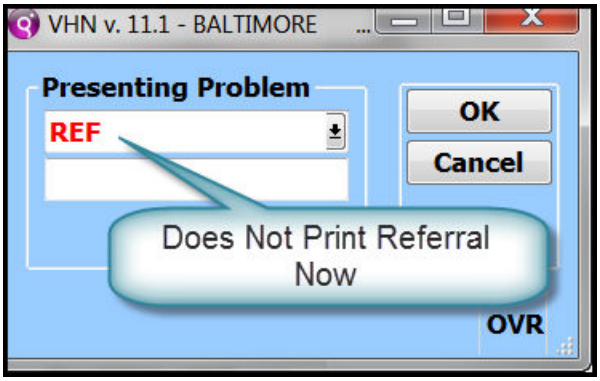
Request stand alone patient labels to be added to dashboard. Indicate to what menu to add the items. Indicate if a toolbar icon is needed. Allow 7-10 working days for item to be scheduled and installed

1. Access the menu option for the Patient Labels
    1. Menu displays: same list of labels as accessed from Patient Central Registry
    2. Select label needed
    3. Enter patient number in the screen and click OK
    4. Select number of labels to print
    5. Labels will print

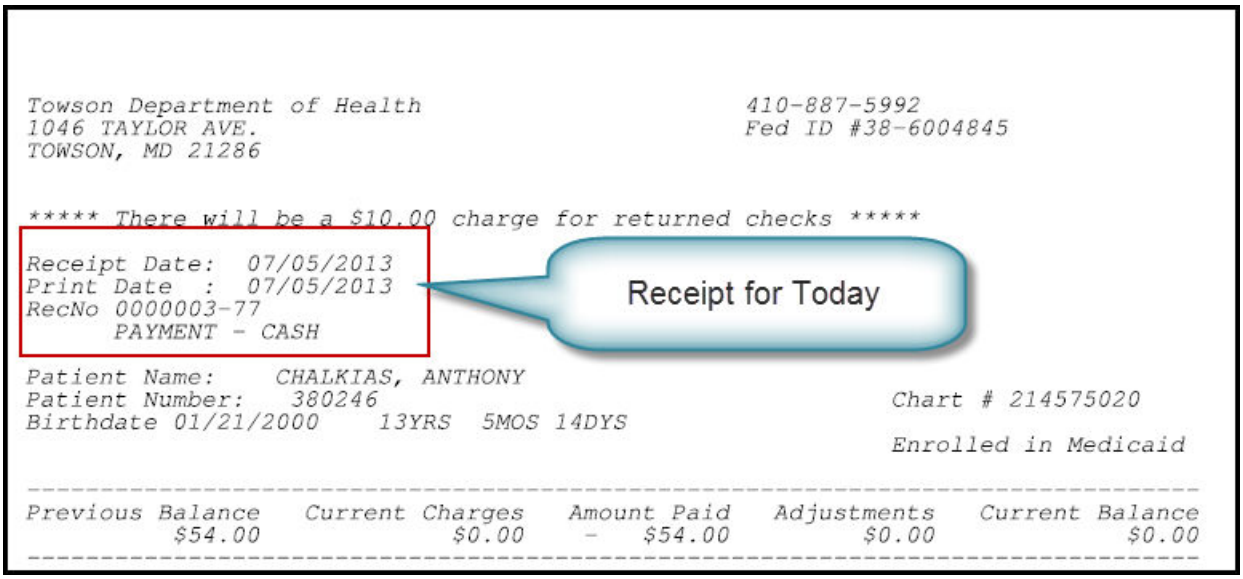


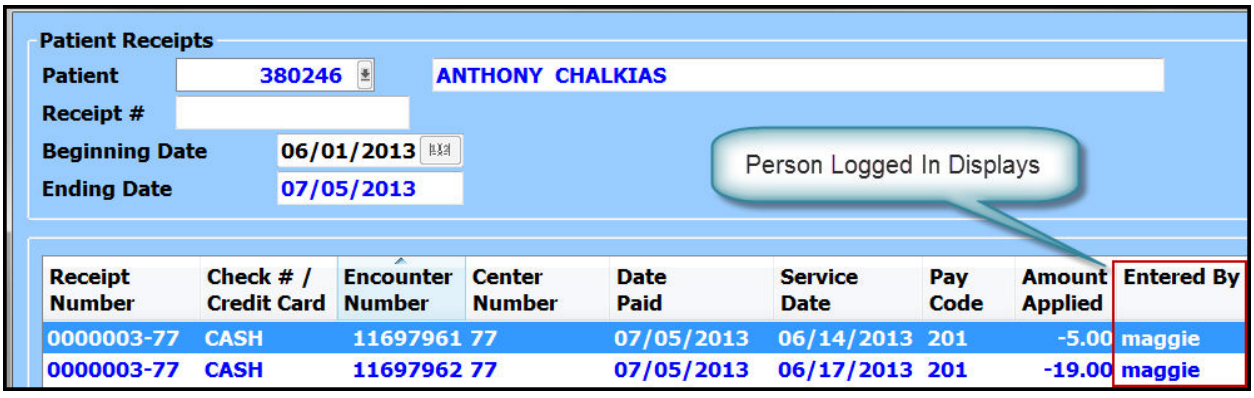


2. Service Slip: Presenting Problem
    1. Referral does not print when **REF** is entered as presenting problems

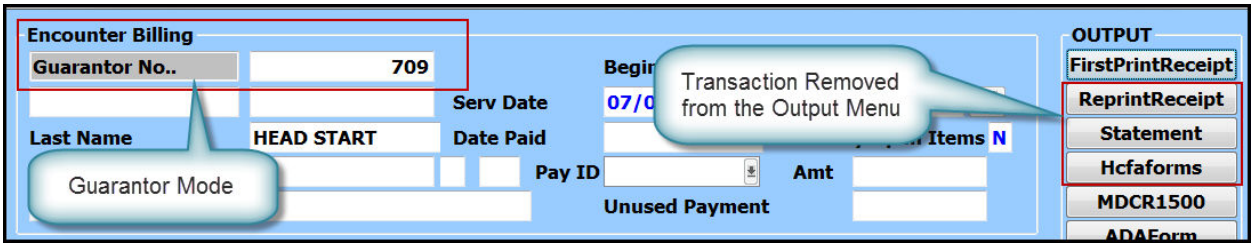


3. Receipt screen displays user logged in at time receipt was printed
    1. Print receipt
    2. View receipt options from menu

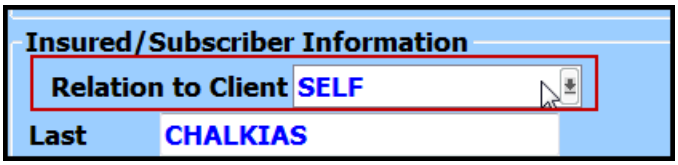




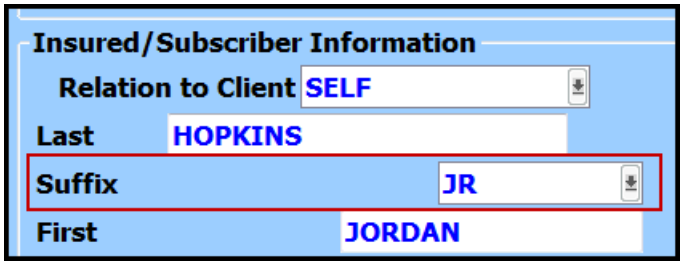
4. Transaction List
    1. Transaction List has been remove from Output in Guarantor Mode
        1. Print from Patient Mode if a parent needing a Transaction Statement for a child
        2. Print statements from the Guarantor Mode



5. 3pInsurance page
    1. Relation to client field expanded
        1. Displays description rather than the code
        2. Allows user to readily note the person insured's relationship to client



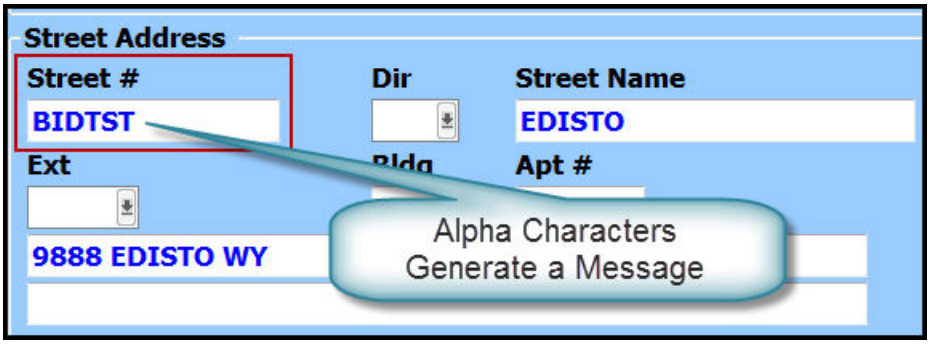
    2. Suffix added to Patient's name
        1. Required by some insurances
        2. Enter on page 1 of Patient Central Registry to insert automatically into Suffix field
        3. Does not insert into Patient Central Registry if entered first on 3Pinsurance screen

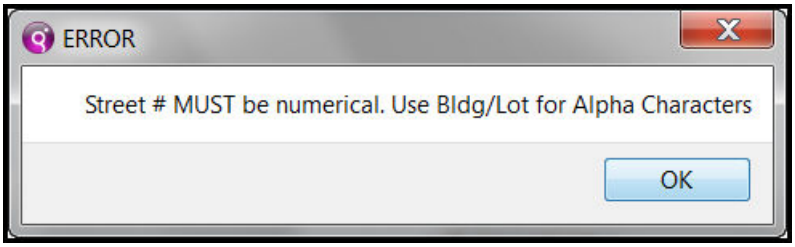


Specific States

Michigan Only

1. Enter only numeric values in the street number field
    1. Edit check on street number
    2. User no longer able to enter letters or symbols in the street number field
    3. Enter a alpha character and receive a message regarding use of only numeric values
    4. OK message and system moves back to the Street# field





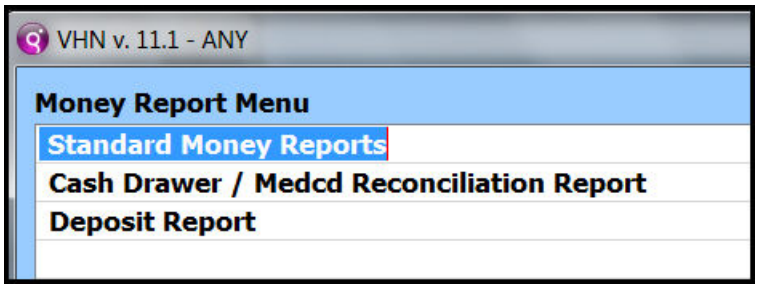
2. Secondary Insurance Claims (CAS Codes)
    1. Adjustments to the billing process made to reflect items not covered by a patient's Secondary Insurance

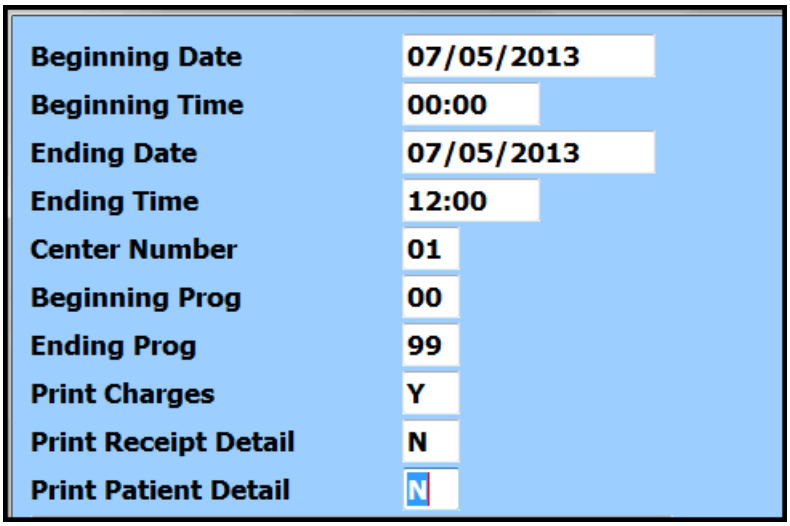
See System Administration Notes for correct method of setting billing flags.

Reports

Daily Money Report

1. Daily Money Report
    1. Prints a summary sheet if totals are $0.00
    2. Continues to print Unposted Advance Payments
    3. No change to how report parameters are entered





TEST COUNTY HEALTH CENTER
Detail of Cash/Check/CredCard Transactions - Totals
Dates:Jun 30, 2013 to Jun 30, 2013
Times: 00:00 thru 23:59
Center: 01-TEST COUNTY HEALTH CENTER
Program: 00 thru 99

Date Printed: Jul 05, 2013 Time: 12:03:12

TOTAL ADJUSTMENTS	$0.00
TOTAL PAYMENTS	$0.00

Prepared By _____

Reviewed By _____

***** There are NO payments posted for this time *****
***** period where the pay date is not the entry date *****

Billing Statements

1. Ability to run statements by center
    1. Center must be marked to Exclude from Regular Billing in the maintenance tables
    2. For Self-Pay and Contractor billing

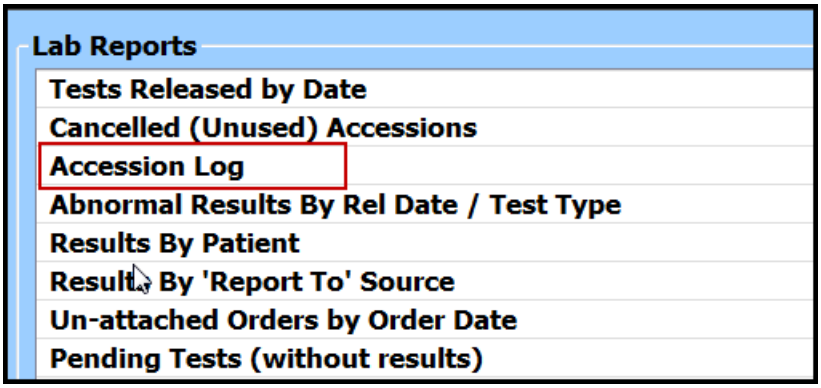
See System Administration notes regarding exclusions

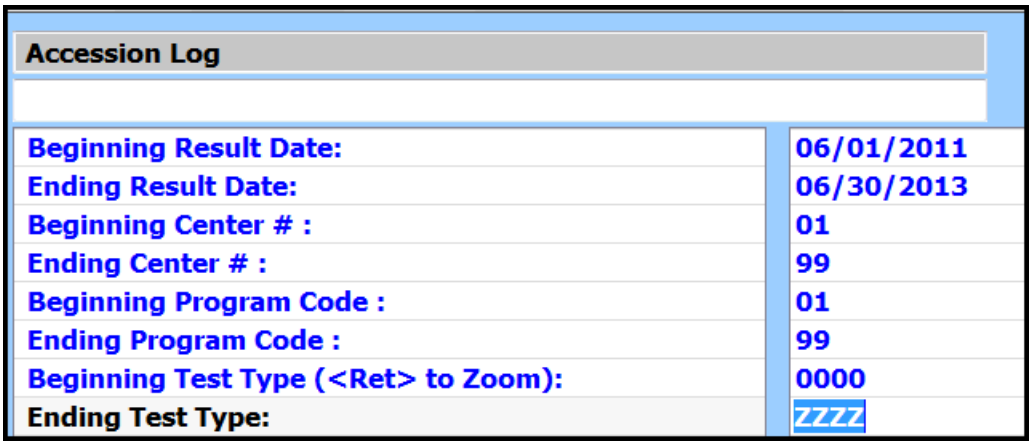
3. Process Statements
    1. Run statements for ALL centers
    2. Run Regular statements: does not include centers marked as exceptions
    3. Run Exception: includes only those centers marked as exceptions
4. Run Statements
    1. Run statements for ALL centers
    2. Run Regular statements: does not include centers marked as exceptions
    3. Run Exception: includes only those centers marked as exceptions

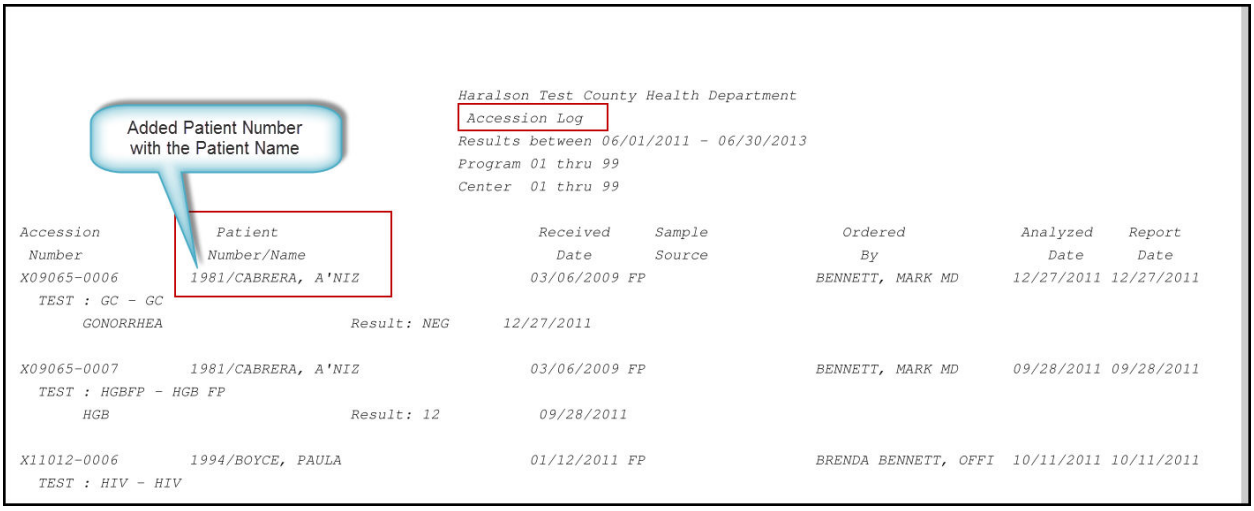
Request new statement options. Indicate what menu to add the items to. Allow 7-10 working days for item to be scheduled and installed

Lab Accession Log

1. Patient number has been added to the Lab Accession Log report
    1. Access the Lab Report Menu
        1. Select the Accession Log report
        2. Complete the parameters
        3. Report runs
    2. Patient number in column with name

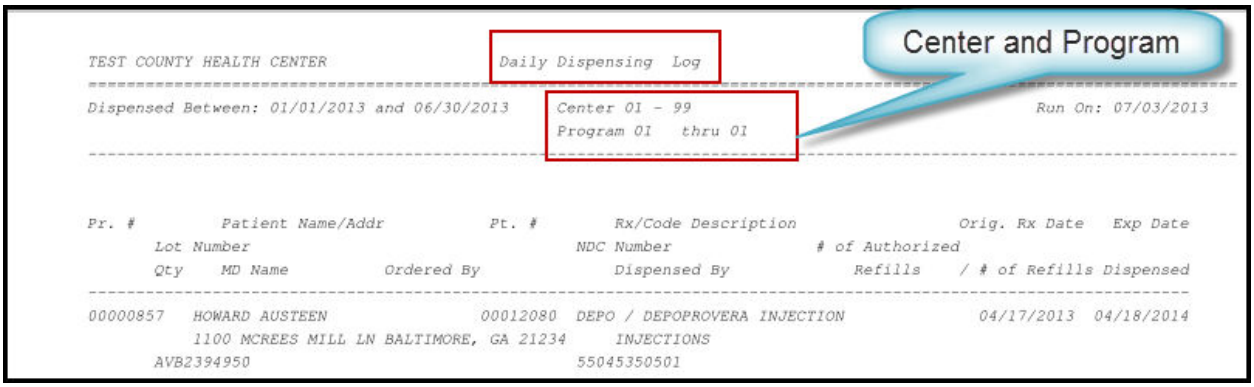

Lab Reports
Tests Released by Date
Cancelled (Unused) Accessions
Accession Log
Abnormal Results By Rel Date / Test Type
Results By Patient
Results By 'Report To' Source
Un-attached Orders by Order Date
Pending Tests (without results)


Accession Log
Beginning Result Date: 06/01/2011
Ending Result Date: 06/30/2013
Beginning Center # : 01
Ending Center # : 99
Beginning Program Code : 01
Ending Program Code : 99
Beginning Test Type (<Ret> to Zoom): 0000
Ending Test Type: zzzz


Added Patient Number with the Patient Name
Haralson Test County Health Department
Accession Log
Results between 06/01/2011 - 06/30/2013
Program 01 thru 99
Center 01 thru 99
Accession Number
Patient Number/Name
Received Date
Sample Source
Ordered By
Analyzed Date
Report Date
X09065-0006 1981/CABRERA, A'NIZ 03/06/2009 FP BENNETT, MARK MD 12/27/2011 12/27/2011
TEST : GC - GC
GONORRHEA Result: NEG 12/27/2011
X09065-0007 1981/CABRERA, A'NIZ 03/06/2009 FP BENNETT, MARK MD 09/28/2011 09/28/2011
TEST : HGBFP - HGB FP
HGB Result: 12 09/28/2011
X11012-0006 1994/BOYCE, PAULA 01/12/2011 FP BRENDA BENNETT, OFFI 10/11/2011 10/11/2011
TEST : HIV - HIV

Pharmacy Dispensing Log

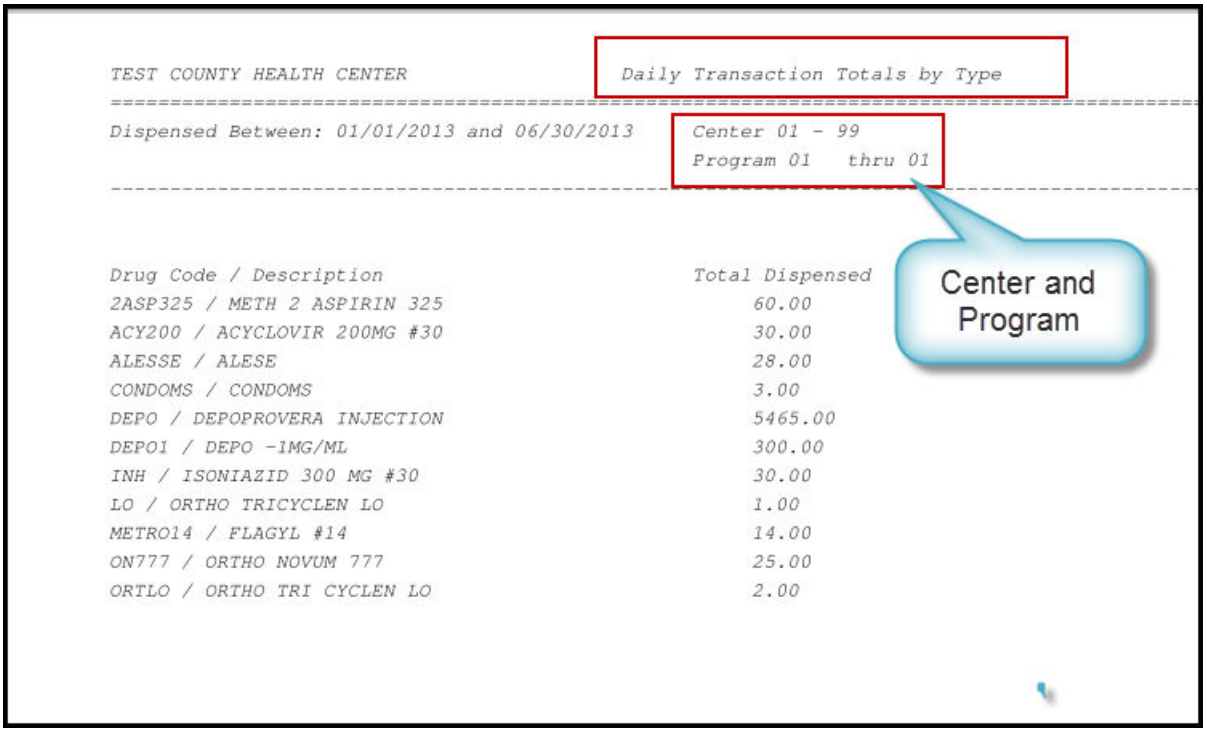
1. Ability to run Dispensing Log by program
    1. Access report as before
    2. Enter report parameters
        1. Beginning and ending date
        2. Beginning and ending center
        3. Beginning and ending program
    3. Prints totals for center and program.



TEST COUNTY HEALTH CENTER — Daily Dispensing Log

Dispensed Between: 01/01/2013 and 06/30/2013 — Center 01 - 99, Program 01 thru 01 — Run On: 07/03/2013

Pr. #	Patient Name/Addr	Pt. #	Rx/Code Description	Orig. Rx Date	Exp Date
	Lot Number		NDC Number	# of Authorized	
	Qty MD Name	Ordered By	Dispensed By	Refills	/ # of Refills Dispensed
00000857	HOWARD AUSTEEN	00012080	DEPO / DEPOPROVERA INJECTION	04/17/2013	04/18/2014
	1100 MCREES MILL LN BALTIMORE, GA 21234		INJECTIONS		
	AVB2394950		55045350501		



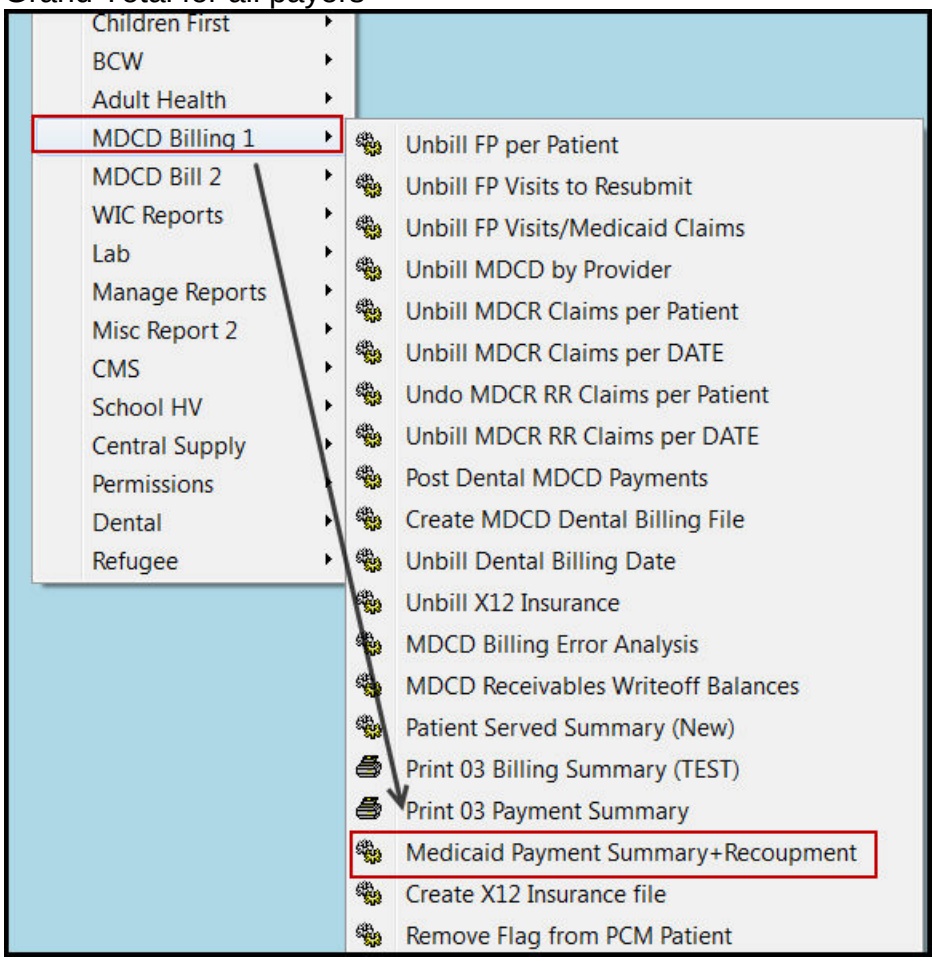
TEST COUNTY HEALTH CENTER — Daily Transaction Totals by Type

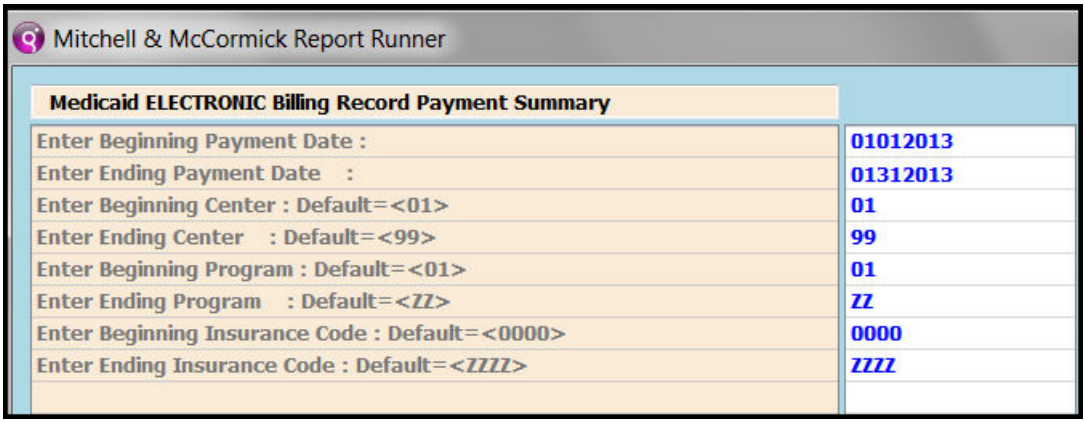
Dispensed Between: 01/01/2013 and 06/30/2013 — Center 01 - 99, Program 01 thru 01

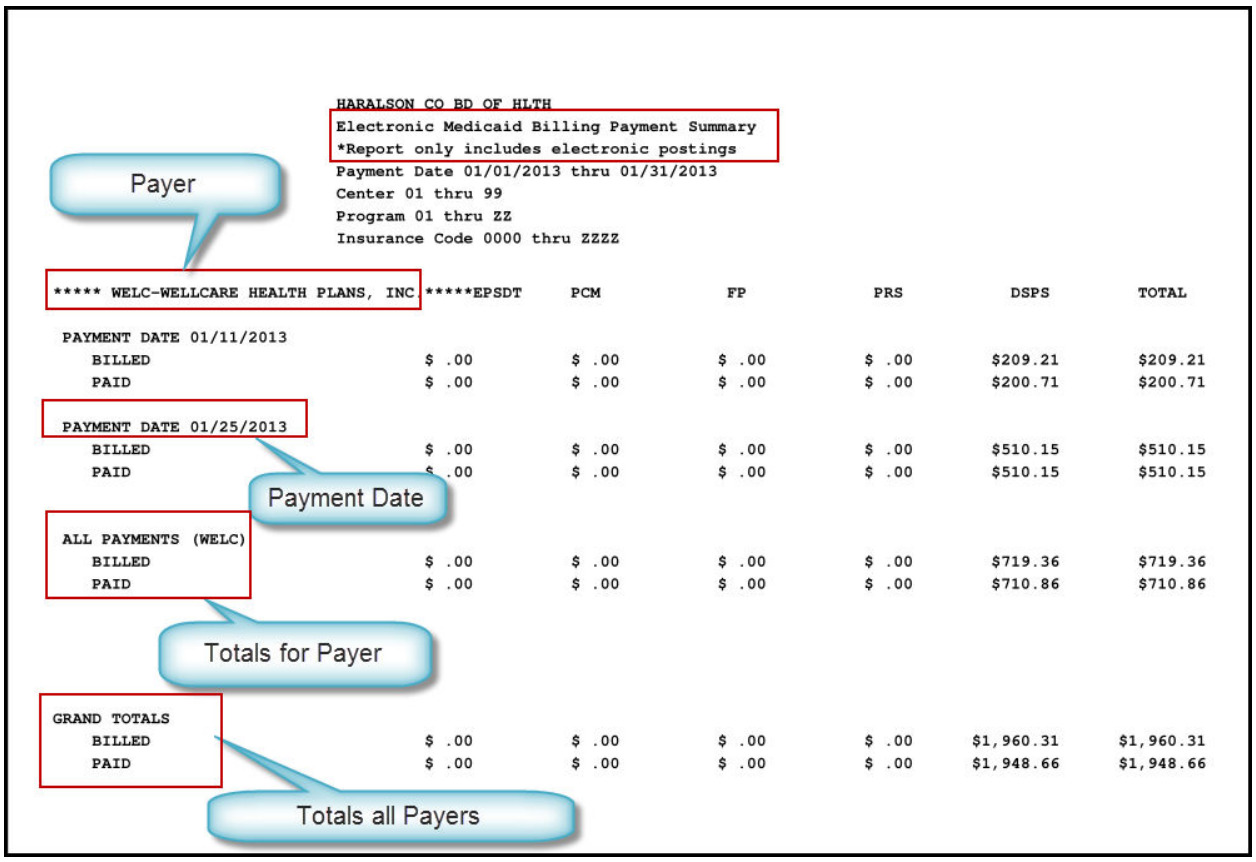
Drug Code / Description	Total Dispensed
2ASP325 / METH 2 ASPIRIN 325	60.00
ACY200 / ACYCLOVIR 200MG #30	30.00
ALESSE / ALESE	28.00
CONDOMS / CONDOMS	3.00
DEPO / DEPOPROVERA INJECTION	5465.00
DEPO1 / DEPO -1MG/ML	300.00
INH / ISONIAZID 300 MG #30	30.00
LO / ORTHO TRICYCLEN LO	1.00
METRO14 / FLAGYL #14	14.00
ON777 / ORTHO NOVUM 777	25.00
ORTLO / ORTHO TRI CYCLEN LO	2.00

Georgia Billing Reports

1. New report for electronic billing and posting of Medicaid
    1. Medicaid Payment Summary + Recoupment
    2. Run report from MDCD Billing screen
        1. Sorted by payer
        2. Reports:
            1. EPSDT
            2. PCM
            3. FP
            4. PRS
            5. DSPS
            6. Totals
        3. Reports by payment date
        4. Totals payments by payer
        5. Grand Total for all payers



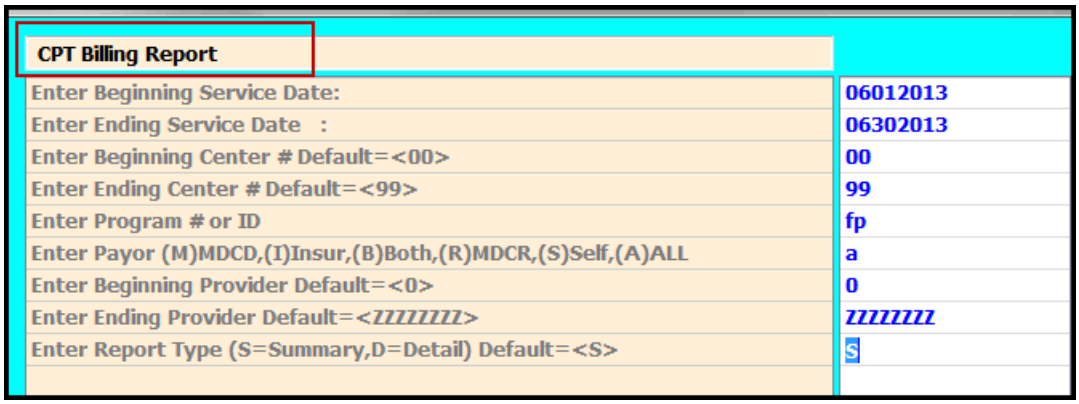

Mitchell & McCormick Report Runner
Medicaid ELECTRONIC Billing Record Payment Summary
Enter Beginning Payment Date : 01012013
Enter Ending Payment Date : 01312013
Enter Beginning Center : Default=<01> 01
Enter Ending Center : Default=<99> 99
Enter Beginning Program : Default=<01> 01
Enter Ending Program : Default=<ZZ> ZZ
Enter Beginning Insurance Code : Default=<0000> 0000
Enter Ending Insurance Code : Default=<ZZZZ> ZZZZ

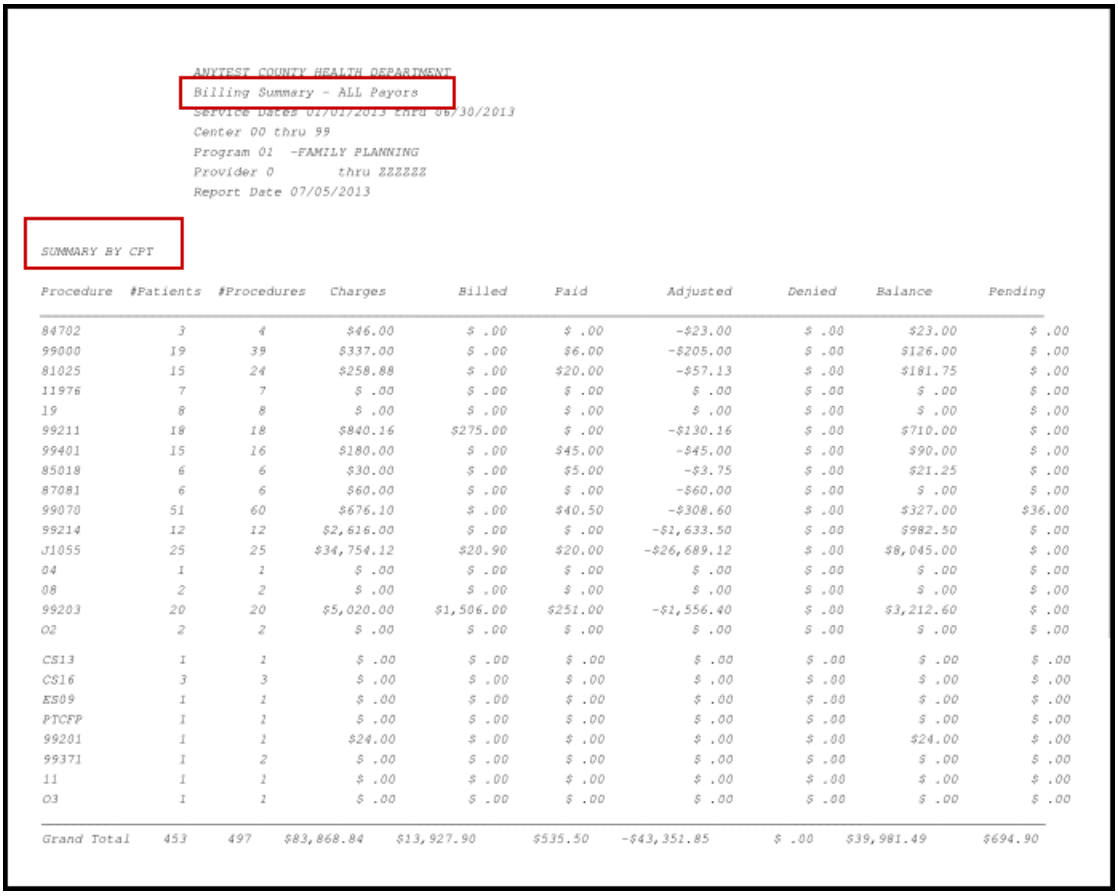

HARALSON CO BD OF HLTH
Electronic Medicaid Billing Payment Summary
*Report only includes electronic postings
Payment Date 01/01/2013 thru 01/31/2013
Center 01 thru 99
Program 01 thru ZZ
Insurance Code 0000 thru ZZZZ
Payer
***** WELC-WELLCARE HEALTH PLANS, INC *****EPSDT PCM FP PRS DSPS TOTAL
PAYMENT DATE 01/11/2013
BILLED $ .00 $ .00 $ .00 $ .00 $209.21 $209.21
PAID $ .00 $ .00 $ .00 $ .00 $200.71 $200.71
PAYMENT DATE 01/25/2013
BILLED $ .00 $ .00 $ .00 $ .00 $510.15 $510.15
PAID $ .00 $ .00 $ .00 $ .00 $510.15 $510.15
Payment Date
ALL PAYMENTS (WELC)
BILLED $ .00 $ .00 $ .00 $ .00 $719.36 $719.36
PAID $ .00 $ .00 $ .00 $ .00 $710.86 $710.86
Totals for Payer
GRAND TOTALS
BILLED $ .00 $ .00 $ .00 $ .00 $1,960.31 $1,960.31
PAID $ .00 $ .00 $ .00 $ .00 $1,948.66 $1,948.66
Totals all Payers

2. RevMax Report
    1. Report will suppress any CPT codes that have the prefix LU (Local Use)
    2. Will not see LU codes on the report
    3. No other changes to report

3. Supplemental Billing Summary Report
    1. Sorts by CPT Codes
    2. Displays for all Payers
    3. Displays totals for centers, providers by program. Does not sort by center or provider
    4. Displays by:
        1. Number of patients
        2. Number of procedures
        3. Charges
        4. Payments
        5. Adjusted
        6. Denied
        7. Balances
        8. Pending charges
    5. Provides Grand Totals for all columns

Request report. Indicate what menu to add the report to. Allow 7-10 working days for item to be scheduled and installed.


CPT Billing Report
Enter Beginning Service Date: 06012013
Enter Ending Service Date : 06302013
Enter Beginning Center # Default=<00> 00
Enter Ending Center # Default=<99> 99
Enter Program # or ID fp
Enter Payor (M)MDCD,(I)Insur,(B)Both,(R)MDCR,(S)Self,(A)ALL a
Enter Beginning Provider Default=<0> 0
Enter Ending Provider Default=<ZZZZZZZZ> ZZZZZZZZ
Enter Report Type (S=Summary,D=Detail) Default=<S> S



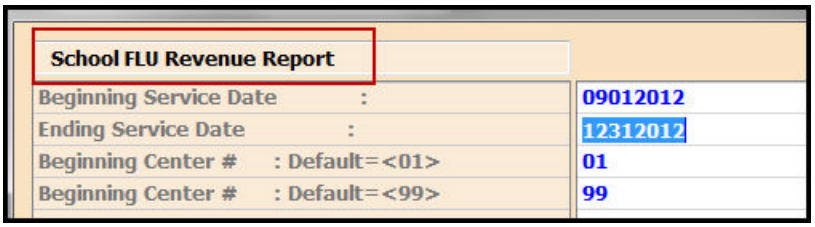
ANYTEST COUNTY HEALTH DEPARTMENT
Billing Summary - ALL Payors
Service Dates 07/01/2013 thru 06/30/2013
Center 00 thru 99
Program 01 -FAMILY PLANNING
Provider 0 thru ZZZZZZ
Report Date 07/05/2013

SUMMARY BY CPT

Procedure	#Patients	#Procedures	Charges	Billed	Paid	Adjusted	Denied	Balance	Pending
84702	3	4	$46.00	$ .00	$ .00	-$23.00	$ .00	$23.00	$ .00
99000	19	39	$337.00	$ .00	$6.00	-$205.00	$ .00	$126.00	$ .00
81025	15	24	$258.88	$ .00	$20.00	-$57.13	$ .00	$181.75	$ .00
11976	7	7	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
19	8	8	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
99211	18	18	$840.16	$275.00	$ .00	-$130.16	$ .00	$710.00	$ .00
99401	15	16	$180.00	$ .00	$45.00	-$45.00	$ .00	$90.00	$ .00
85018	6	6	$30.00	$ .00	$5.00	-$3.75	$ .00	$21.25	$ .00
87081	6	6	$60.00	$ .00	$ .00	-$60.00	$ .00	$ .00	$ .00
99070	51	60	$676.10	$ .00	$40.50	-$308.60	$ .00	$327.00	$36.00
99214	12	12	$2,616.00	$ .00	$ .00	-$1,633.50	$ .00	$982.50	$ .00
J1055	25	25	$34,754.12	$20.90	$20.00	-$26,689.12	$ .00	$8,045.00	$ .00
04	1	1	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
08	2	2	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
99203	20	20	$5,020.00	$1,506.00	$251.00	-$1,556.40	$ .00	$3,212.60	$ .00
O2	2	2	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
CS13	1	1	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
CS16	3	3	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
ES09	1	1	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
PTCFP	1	1	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
99201	1	1	$24.00	$ .00	$ .00	$ .00	$ .00	$24.00	$ .00
99371	1	2	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
11	1	1	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
O3	1	1	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00	$ .00
Grand Total	453	497	$83,868.84	$13,927.90	$535.50	-$43,351.85	$ .00	$39,981.49	$694.90

4. School Flu Revenue Report
    1. Non-VFC Flu vaccine that is given in the schools
    2. Reports only payment type 04
    3. Immunizations must be entered with Action Code of S to appear on report
    4. Reports billing per patient
        1. Service Date
        2. Service Code
        3. CPT
        4. Insurance
        5. Charges
        6. Other Payments
        7. Insurance Payments
        8. Adjustments
        9. Write-offs
        10. Current due
    5. Totals columns

Request report. Indicate menu to add the report to. Allow 7-10 working days for item to be scheduled and installed.



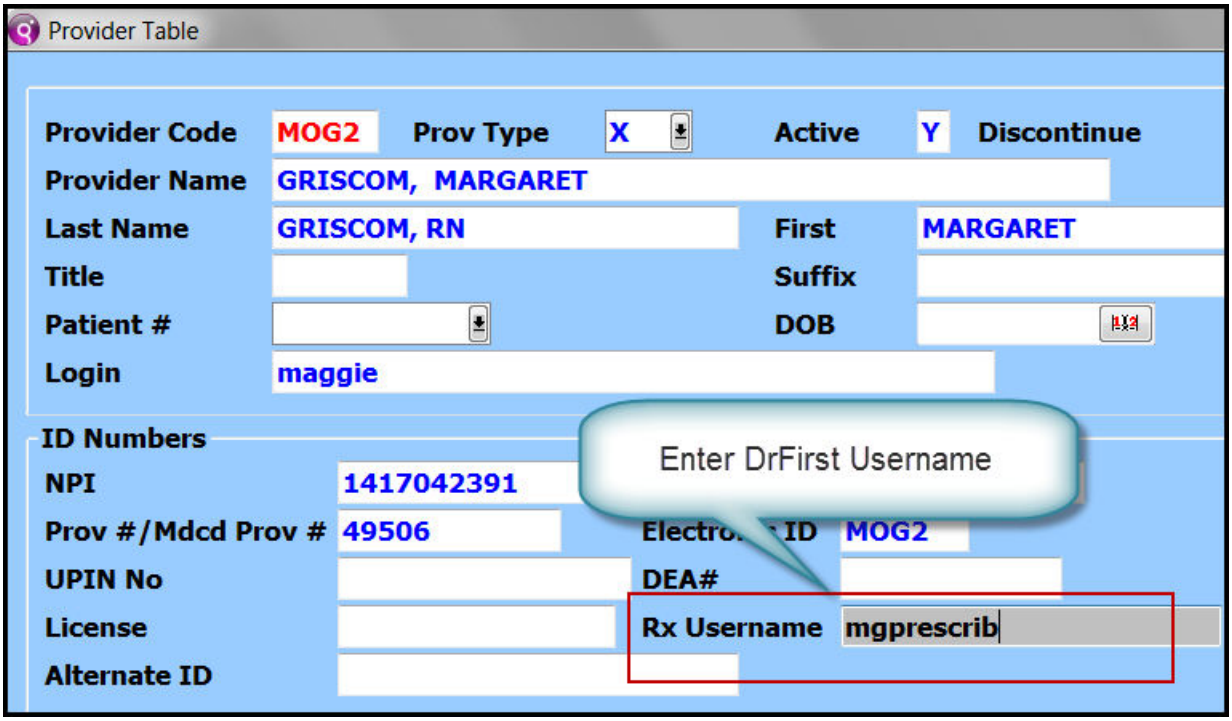
RICHMOND COUNTY HEALTH DEPARTMENT
SCHOOL FLU REVENUE REPORT
COMMERCIAL INSURANCE ONLY
Centers 01 thru 99
Service Date 09/01/2012 thru 12/31/2012

Patient #	Service Date	Service Code	CPT Code	Insurance Code	Charges	Other Payments	Insurance Payments	Adjustments	Write Offs	Current Due
00360380	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360380	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360555	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360555	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360556	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360556	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360557	10/15/2012	SBPF1	90471	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360557	10/15/2012	SBPF1	90658	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360558	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360558	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360559	10/15/2012	SBM1	90471	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360565	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360565	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360568	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360568	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360594	10/15/2012	SBPF1	90471	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360594	10/15/2012	SBPF1	90658	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360616	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360616	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360620	10/15/2012	SBPF1	90471	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360620	10/15/2012	SBPF1	90658	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360624	10/15/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360624	10/15/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360637	10/31/2012	SBPM1	90473	SHPC	13.99	-0.11	0.00	0.00	0.00	13.88
00360637	10/31/2012	SBPM1	90660	SHPC	25.66	-25.66	0.00	0.00	0.00	0.00
00360670	11/01/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360670	11/01/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360673	11/01/2012	SBPM1	90473	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
00360673	11/01/2012	SBPM1	90660	TRIC	0.00	0.00	0.00	0.00	0.00	0.00
TOTALS					1,567.80	-72.52	-1,176.01	0.00	0.00	58.29

System Administration

Providers Table

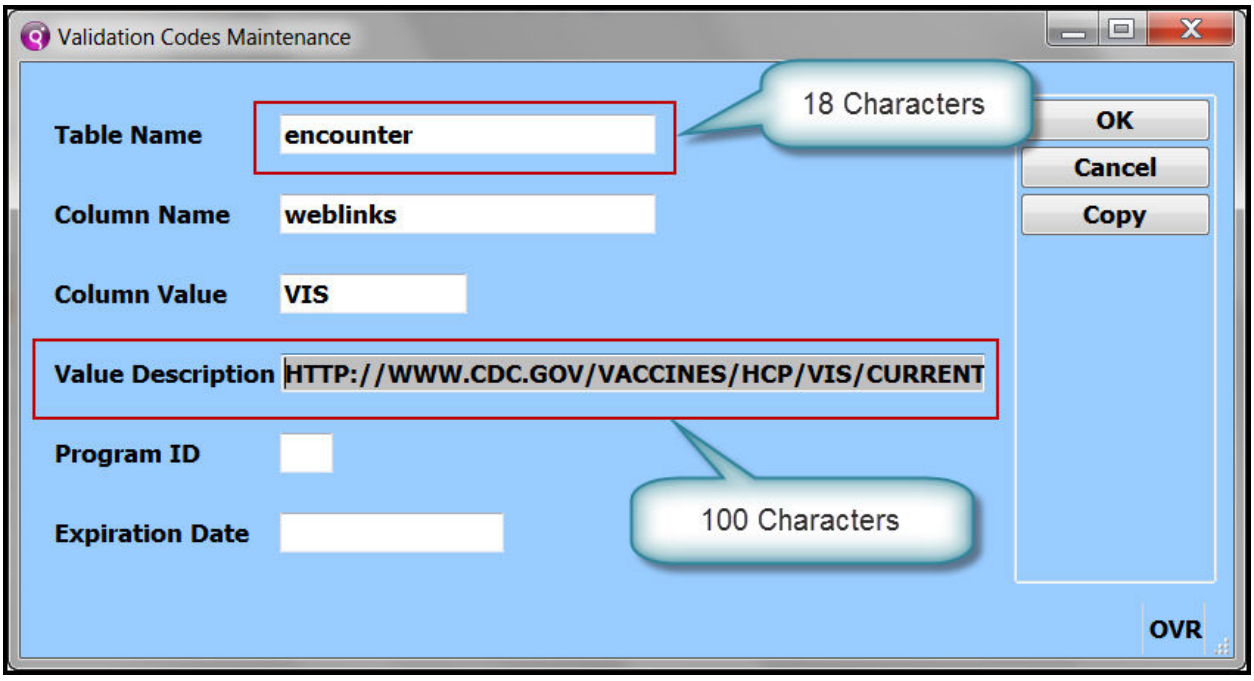
1. Field added for e-prescribing
    1. Field added to store provider's Dr.First Username
        1. Allows provider access to DrFirst without entering another login and password
        2. User profile is immediately available in DrFirst and does not have to be selected from another drop down
        3. User name is provided by DrFirst and included in the Signature sheet that is returned to DrFirst at time of enrollmenmt
    2. Access the Provider Table from the Main Maintenance Table
        1. Query the provider that is e-prescribing medications
        2. Update
        3. Move to the RX Username field
        4. Enter the provider's DrFirst user name



Valid Codes

1. Increase in length of fields
    1. Table name now increased to 18 characters
    2. Description now increased to 100 characters
        1. Accommodates web address for Encounter web links (see Workflow Maintenance)
        2. Scrolls left to right

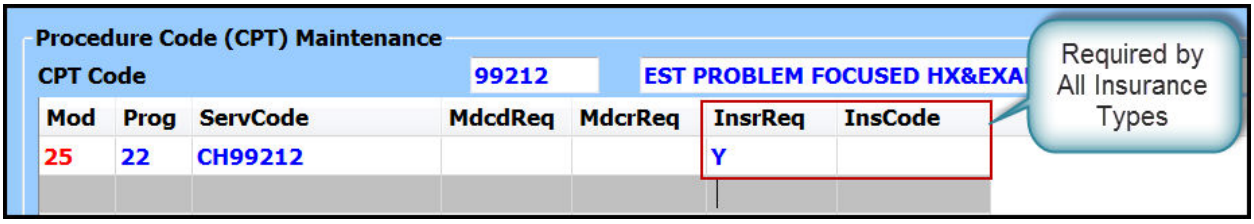
Important! Not all fields throughout the system have been upgraded to accept these increased characters! Be careful about character length with service codes, Immunization etc.



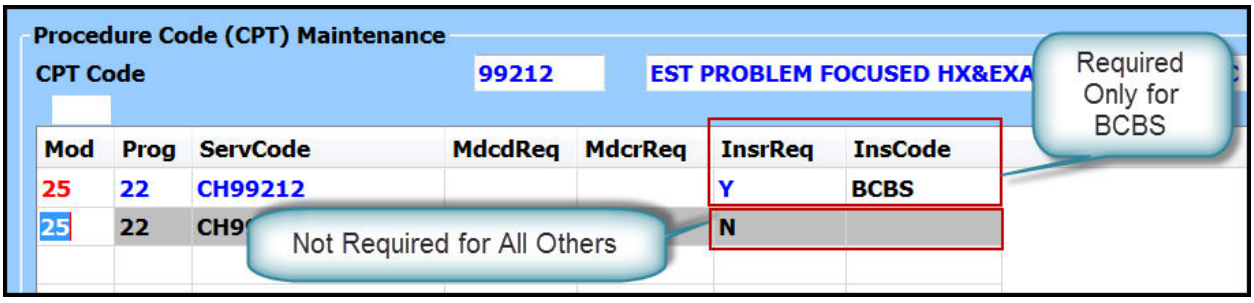
2. TB Medication Discontinue Reason 20
    1. Table name = tbmeds
    2. Column name = disconreason
    3. Column value = 20
    4. Value Description = Medication Shortage

Procedure Codes

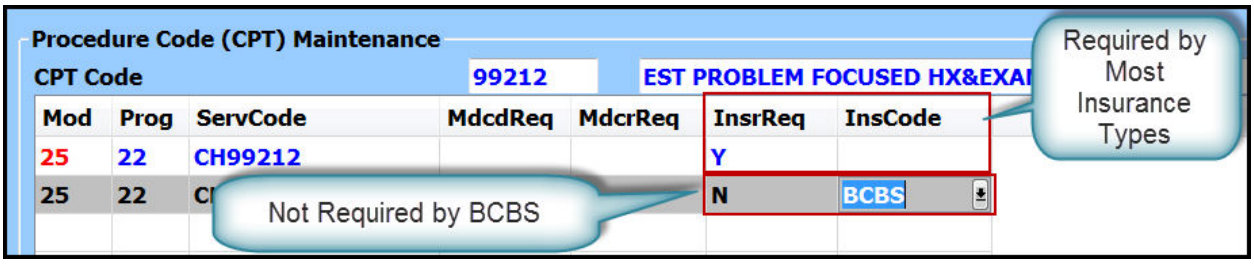
1. Modifiers for 04 Insurance
    1. InsCode field added to specify insurance code
    2. Allows for Modifier to insert automatically on ONLY those insurance types that require a modifier
        1. If modifier is required by all insurance types:
            1. Indicate modifier is required InsrReq = Y
            2. InsCode is blank



3. Modifier required by minimal number of insurance types
    1. InsrReq = Y and InsCode = the insurance code for the payers requiring the modifier
    2. InsrReq = N and leave InsCode blank to cover all other insurances



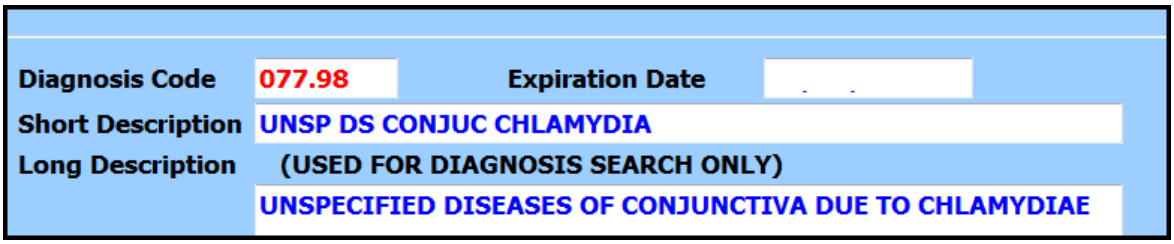
4. Modifier required by most insurance types
    1. InsrReq = Y and InsCode blank to require the modifier for most insurance types
    2. InsrReq = N and InsCode = the insurance codes for the payers that do not require the modifier

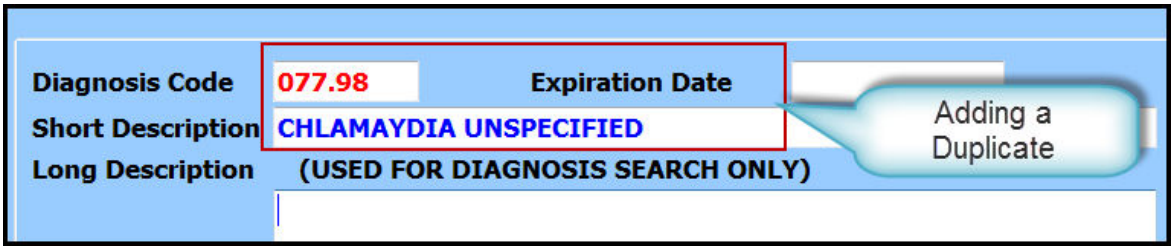


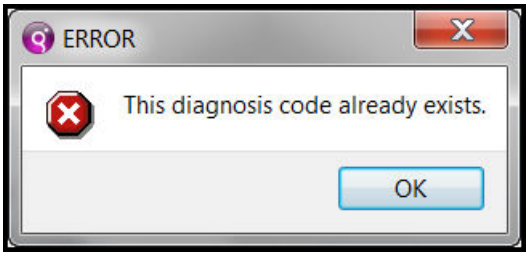
Diagnosis Table

1. System does not allow duplication of diagnosis codes
    1. Add a different description for an existing diagnosis code
        1. Add a diagnosis code to table
        2. Tab to the description
        3. Message displays regarding duplication of code
        4. Query the code and correct the description or add to the long description
    2. Add a new code to replace the expired code
        1. Unexpire the existing code and change the descriptions if needed.

Code descriptions should match true ICD-9 codes as much as possible







Diagnosis Code	077.98	**Expiration Date**	06/01/2012
Short Description	UNSP DS CONJUC CHLAMYDIA		
Long Description	(USED FOR DIAGNOSIS SEARCH ONLY)		
	UNSPECIFIED DISEASES OF CONJUNCTIVA DUE TO CHLAMYDIAE		

System Configuration

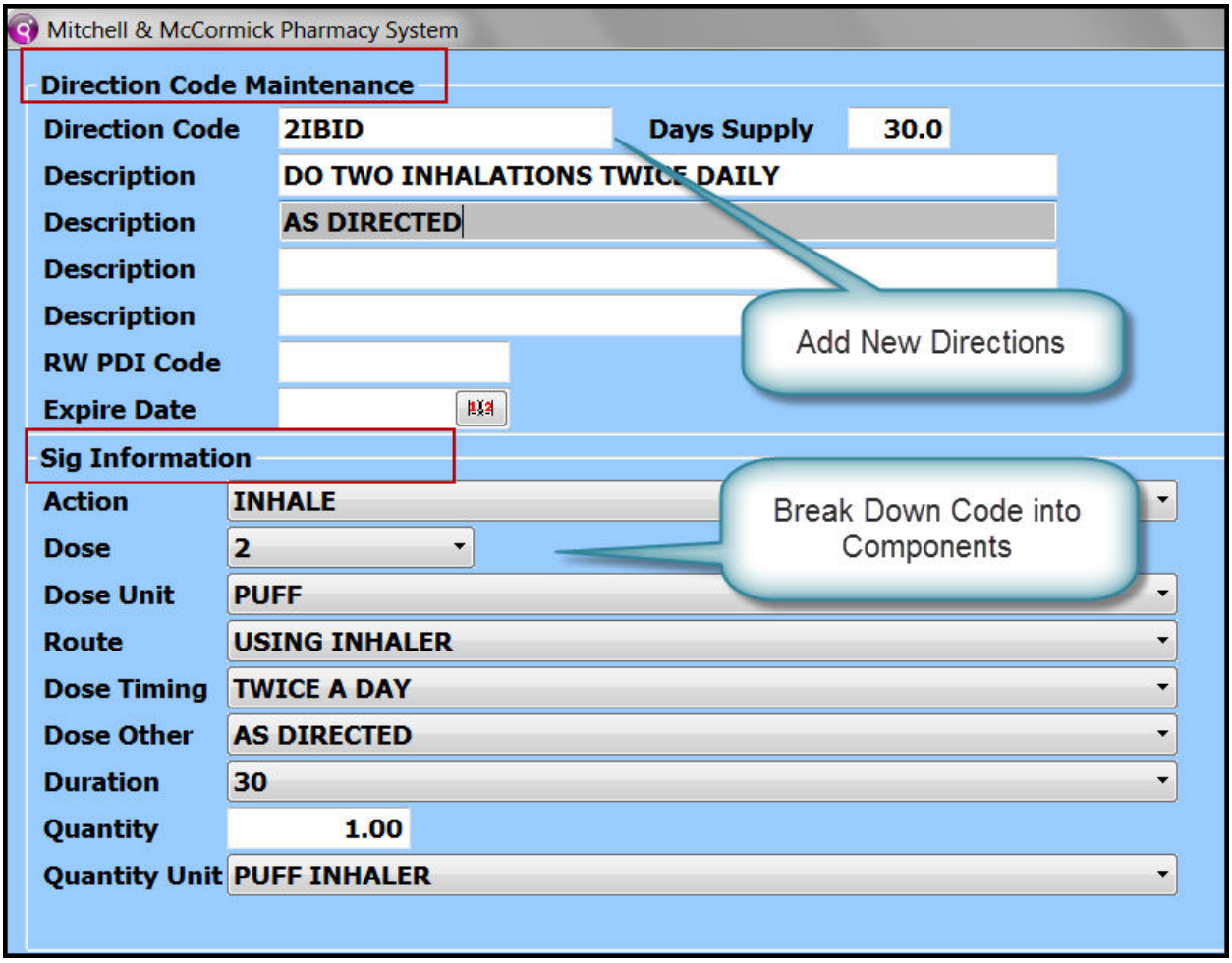
1. Spanish Monographs
    1. New flag to turn availability of Spanish Monographs on or off
    2. To include Spanish Monographs is included in annual maintenance contract
    3. For users that do not choose to use Spanish Monographs
    4. Flag will be set at time of release install as determined by current M&M contract

To have flag changed at any time after current contract year. Please notify Martha Sapp regarding any changes. M&M will set flag after verification with Martha Sapp of contract specifications.

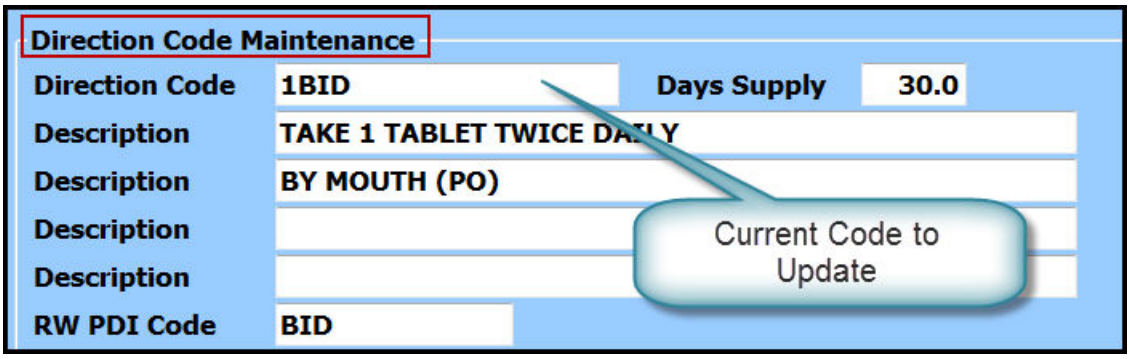
Pharmacy Directions

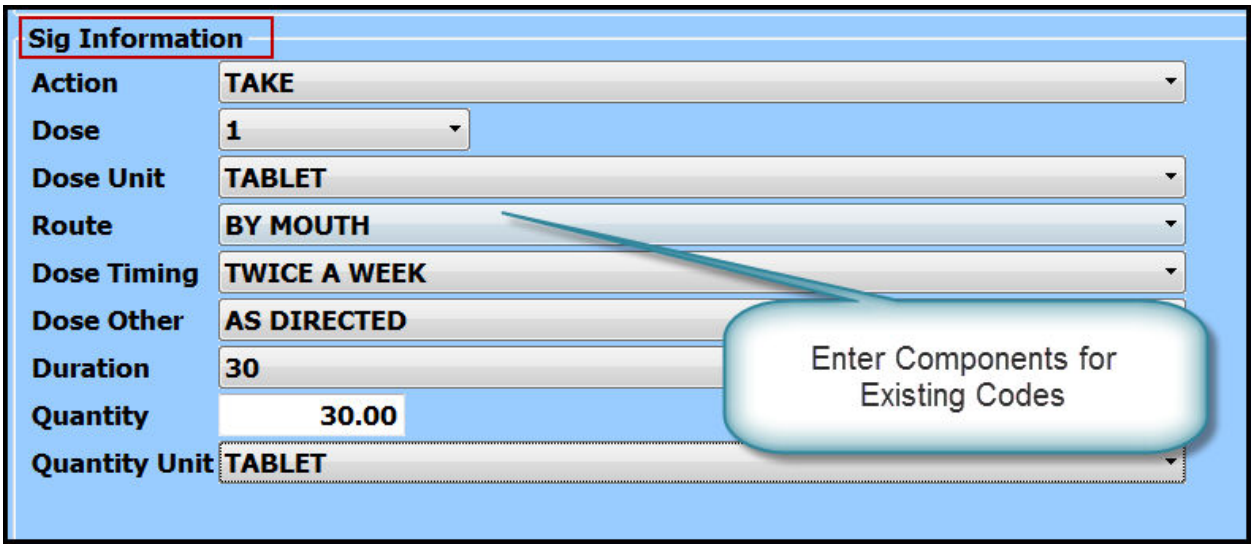
1. Pharmacy Directions table enhanced
    1. Allow users smoother transition from VHN to Rcopia for e-prescribing
    2. Eliminates re-entering the directions while in Rcopia
2. Access the Pharmacy Directions from the More Maintenance menu
    1. Update existing Direction Codes
    2. Choose Add to create new code for e-prescribing
    3. Direction codes are used for all prescribing methods
3. Drop downs in the Sig Information portion of the screen currently correspond to the drop downs in the Rcopia application
    1. This portion of the screen needs to be populated only for those items used in e-prescribing
        1. For clinics only using e-prescribing all codes should have the additional information
        2. If not doing e-prescribing this step is not necessary
        3. If doing both e-prescribing and in-house orders codes used for both functions need to include the additional information
    2. Valid Codes for these drop downs will be loaded during the release install
        1. Table is phdir
        2. Columns are:
            1. Action
            2. Dose
            3. Doseother
            4. Dosetiming
            5. Doseunit
            6. Drugroute
            7. Duration
            8. Quantityunit

4. Add new directions:



5. Update current directions with Sig components

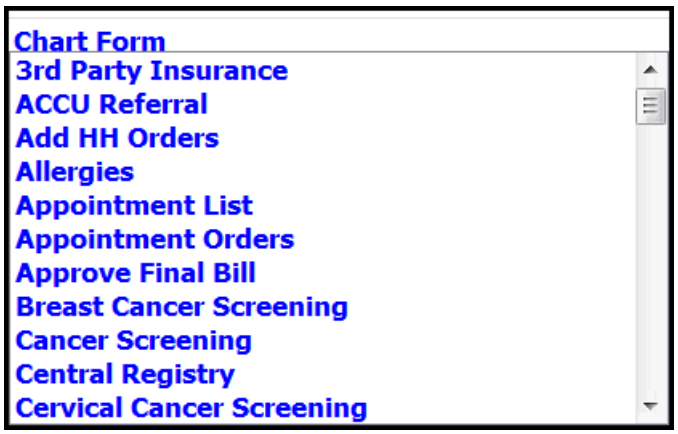



Sig Information
Action
TAKE
Dose
1
Dose Unit
TABLET
Route
BY MOUTH
Dose Timing
TWICE A WEEK
Dose Other
AS DIRECTED
Duration
30
Quantity
30.00
Quantity Unit
TABLET
Enter Components for Existing Codes

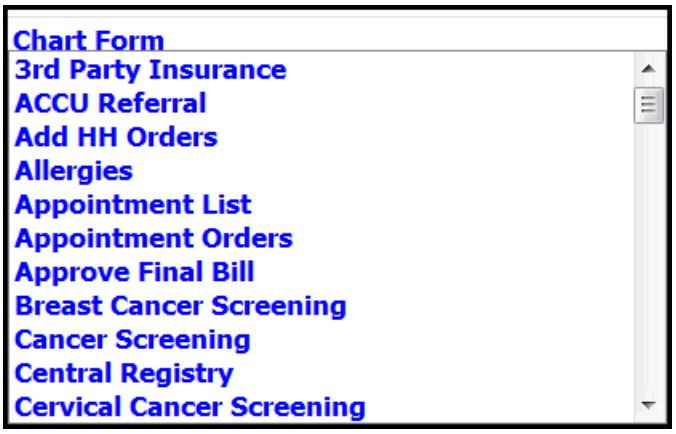
Workflow Maintenance

1. Drop down functions
    1. Step Name displays in alphabetical order
    2. Step Detail in alphabetical order. Has a zoom function
    3. Time and Activity Codes in alphabetical order

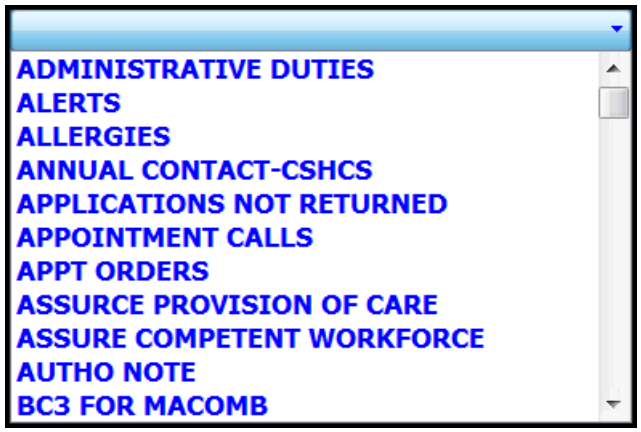
Step Name



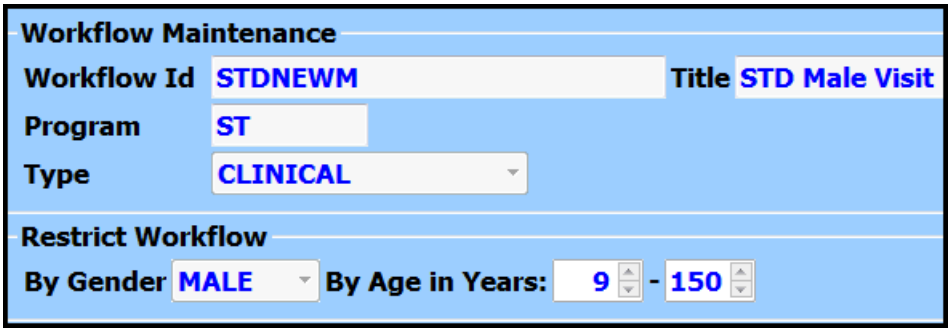
Step Detail

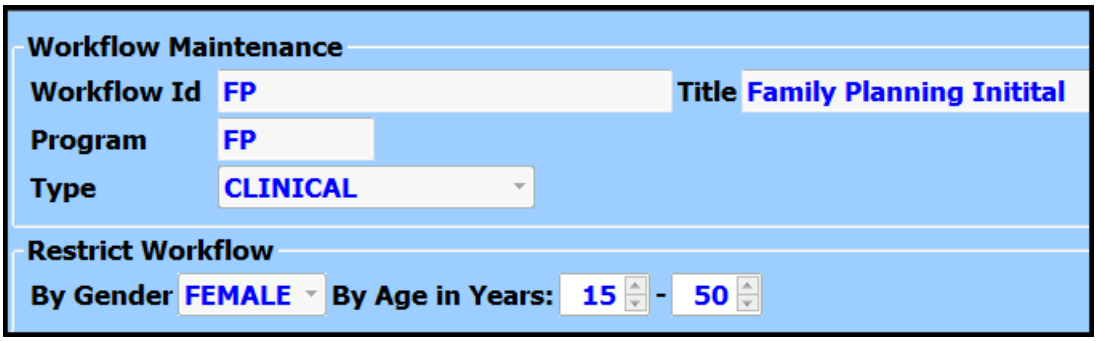


Time and Activity Codes

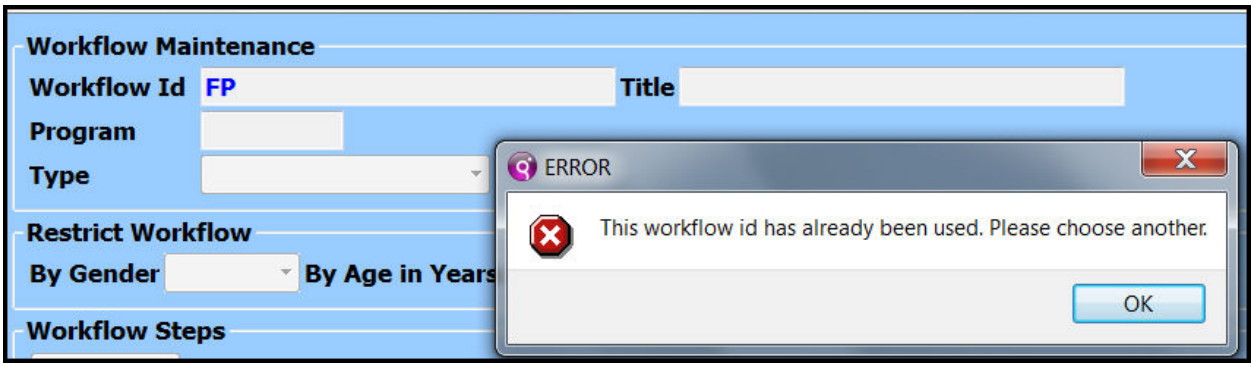


2. Gender and Age restrictions
    1. Workflow only displays when patient age and gender matches the items in maintenance
    2. Allows shorter list based on age as in Child Health
    3. Gender restrictions allow only Male and Female work flows
    4. Use both options or either Gender or age depending on workflow
    5. For established work flows
        1. Query the workflow
        2. Update
        3. Enter the Gender and/or age range
    6. New work flows: complete when creating the new workflow





3. Duplicate Workflow IDs
    1. Warning message displays if user tries to create a new workflow with the same ID as one already in place



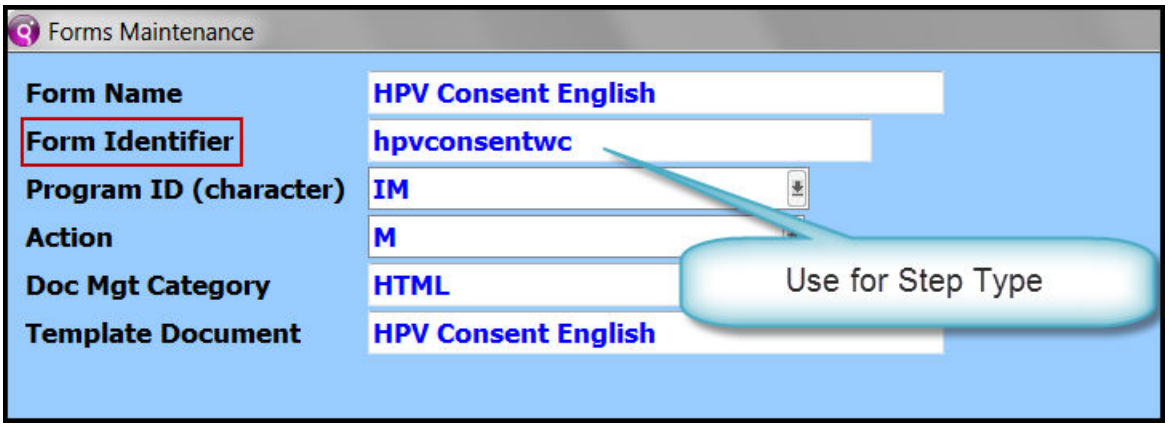
4. Workflow Maintenance for Clinical Encounter:

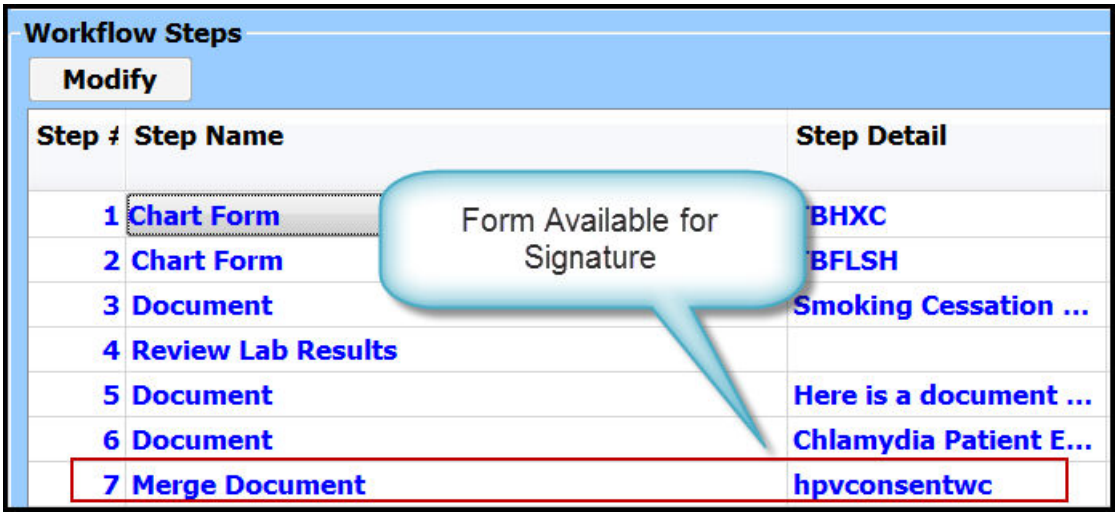
See Clinical Encounter notes for use of each item

1. Workflow now used to complete Clinical Encounter
2. Items that replace the any drop downs will use the same codes. Codes do not have to be redone
3. New items added for Encounter Set-up
    1. Encounter Info
        1. Visit Type
        2. Walk-in check box
        3. Confidential check box
        4. Providers/Time
    2. Office Visit
        1. Office Visit
            1. Types of office visits: General, Preventive, Counseling
            2. Drop down to select office visit
        2. Problem List
            1. Displays Primary Diagnosis code
            2. Ability to access Problem List to add/change or re-prioritize the diagnosis for this visit
    3. Procedures: access to the procedure table (drop down)
    4. Education: Access the education topics/other services drop down
    5. Program Details: Access to items currently under program details
    6. Progress Notes: Access to progress note screen
    7. Prioritize Diagnosis: Prioritize Diagnosis screen

8. Check Encounter: Checks the encounter to assure billing/required items are complete
9. Cancer Screening: Access to the Breast and Cervical cancer menu
10. Miscellaneous orders: Takes users to the miscellaneous order details

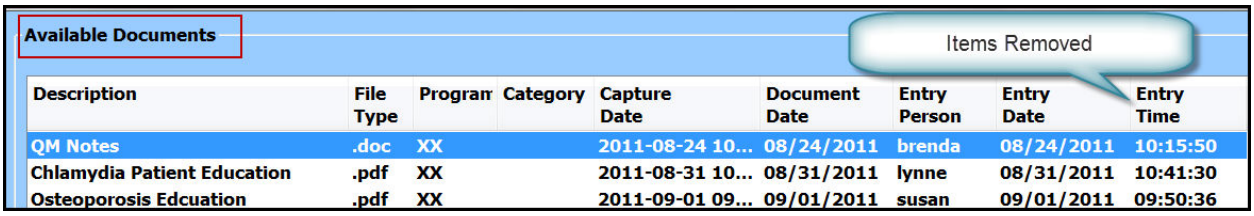
5. Default workflow
    1. Default work flow/Standard work flow
    2. System defaults to this work flow if no encounter has been created
    3. Can be update locally
    4. Can only have one Default work flow
    5. Loaded by M&M during release install
6. Signing documents
    1. Allows users to sign consents, forms from the work flow
    2. Option is Merge Document
        1. Step Name is Merge Document
        2. Step Type is the Form Identifier from the Forms table




Workflow Steps
Modify
Step # Step Name Step Detail
1 Chart Form BHXC
2 Chart Form BFLSH
3 Document Smoking Cessation ...
4 Review Lab Results
5 Document Here is a document ...
6 Document Chlamydia Patient E...
7 Merge Document hpvconsentwc
Form Available for Signature

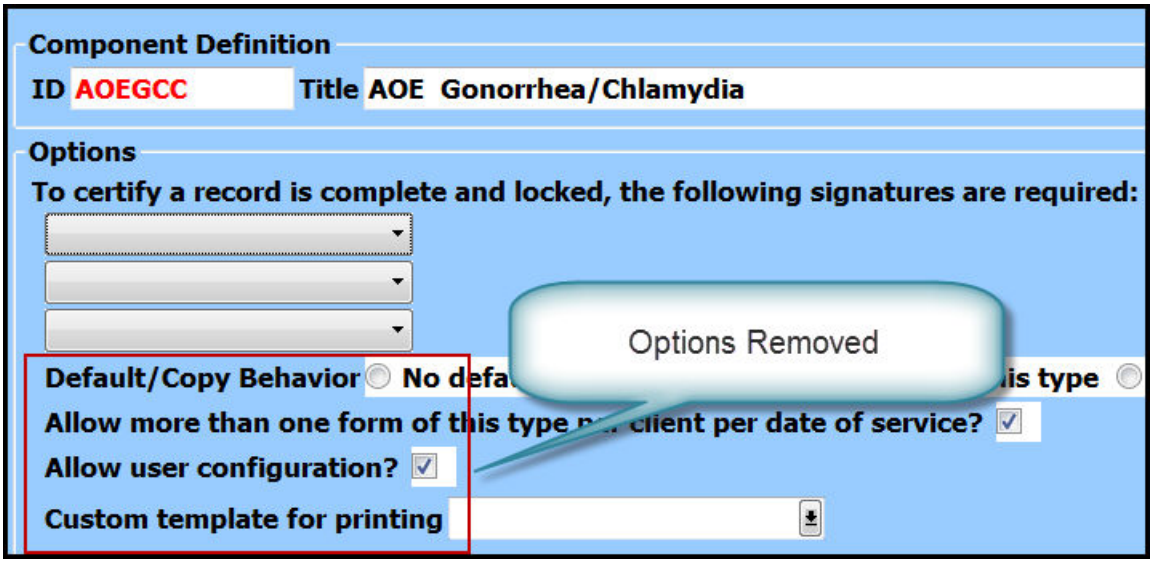
Load Documents

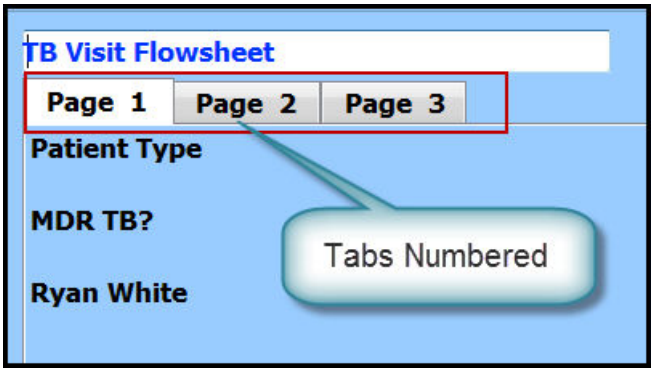
1. Load Documents screen modified
    1. Update date removed from screen
    2. Updated by removed from screen
    3. Items not used so removed from display
    4. Category function still in development



E-charting Maintenance

1. Paged formatting removed
    1. Tabbed forms now the only option
    2. User no longer has an option for the Paged or Tabbed
    3. Previously Paged e-charts
        1. Will default to Tabbed
        2. Release install when insert page breaks
        3. Tabs will be numbered



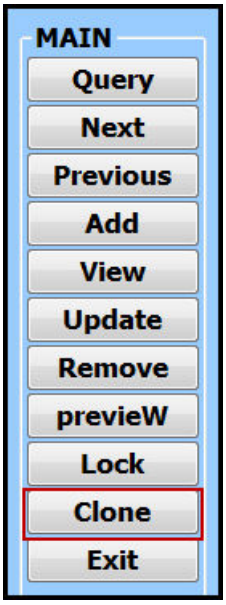


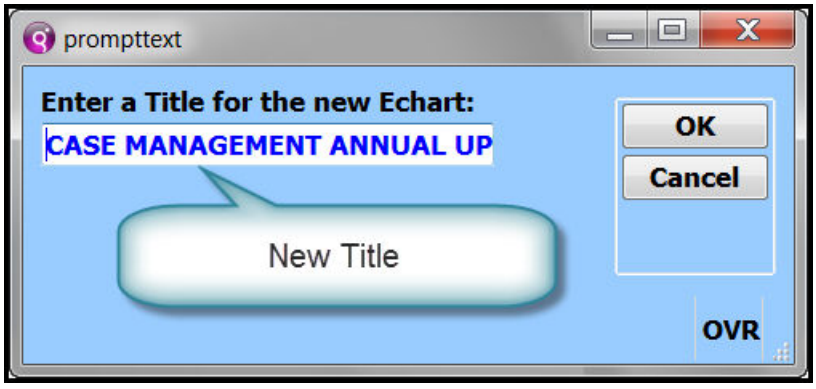
See current Maintenance Manual for Tabbed pages

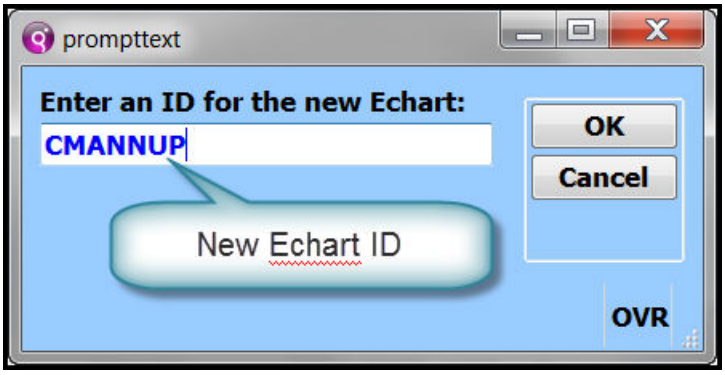
2. Cloning
    1. Users are now able to clone and rename e-charts to create new e-charts
        1. Use:
            1. Creating multiple e-charts for different age groups where information needs to pull forward

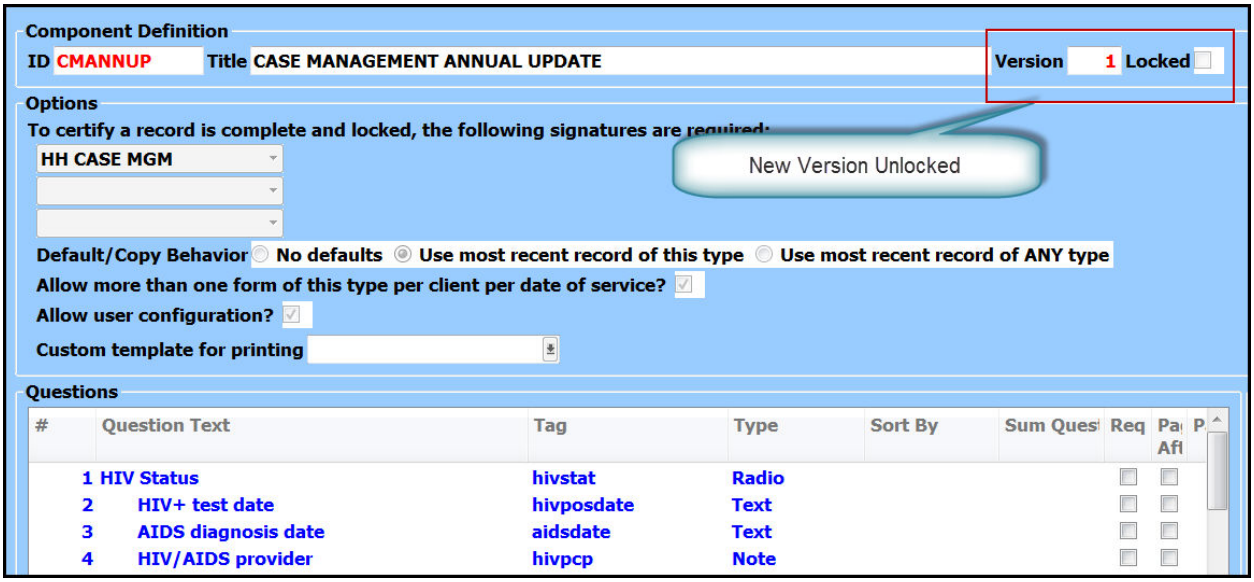
2. Creating female versus male e-charts with a majority of similar tags
3. Creating modified versions of an e-chart for different visit types. An annual physical versus a routine visit.

2. Query the e-chart to be cloned
    1. Click the Clone button
    2. Enter a New ID. OK
    3. Enter a New Title. OK
    4. Message displays that the E-chart was successfully cloned. This is version 1 of the new e-chart
    5. Update and make the needed changes or adjustments.
    6. When complete lock the new version of the cloned e-chart

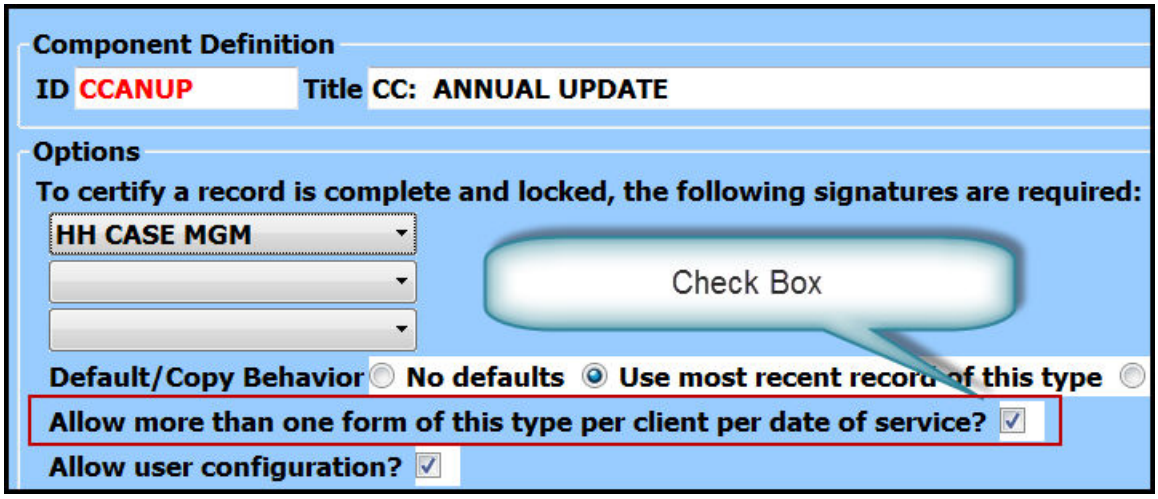




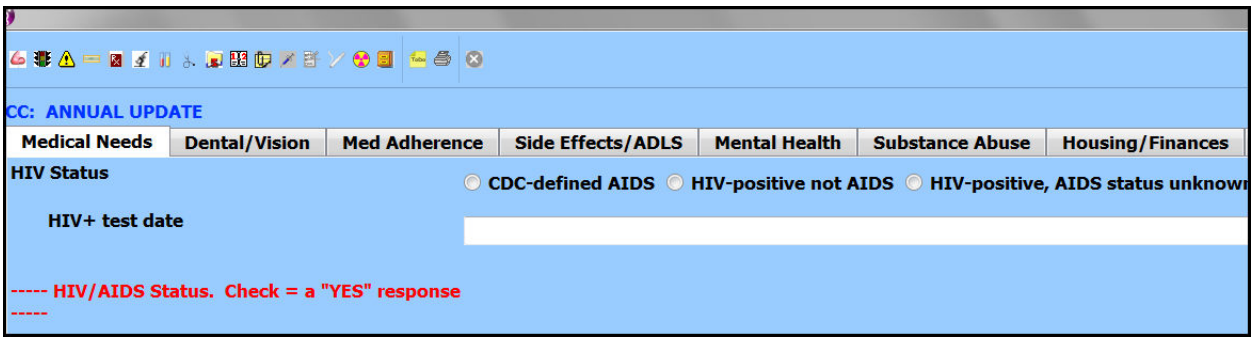


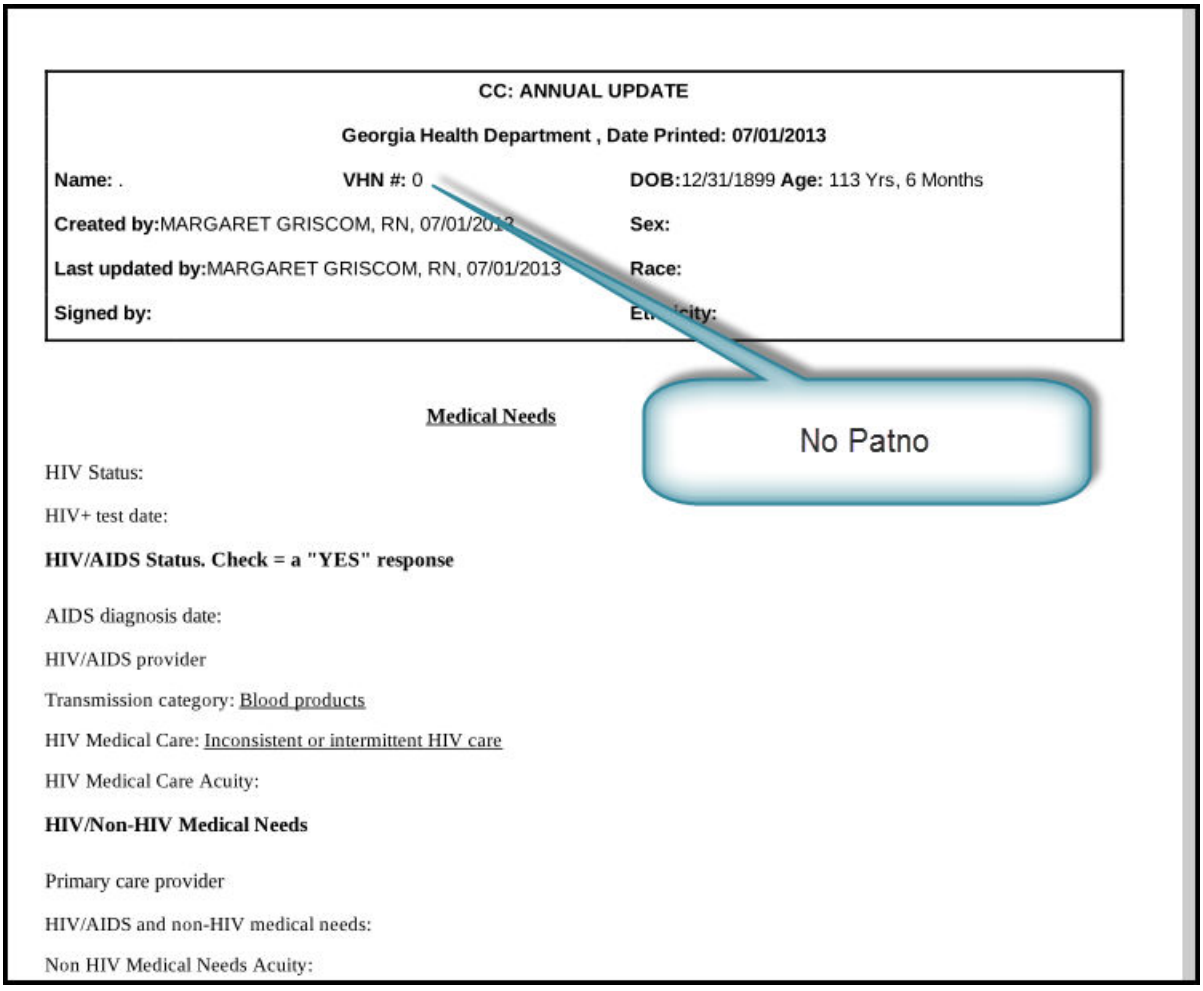

Component Definition
ID CMANNUP
Title CASE MANAGEMENT ANNUAL UPDATE
Version 1
Locked
Options
To certify a record is complete and locked, the following signatures are required:
HH CASE MGM
New Version Unlocked
Default/Copy Behavior
No defaults
Use most recent record of this type
Use most recent record of ANY type
Allow more than one form of this type per client per date of service?
Allow user configuration?
Custom template for printing
Questions
Question Text Tag Type Sort By Sum Ques Req Pa Afl P
1 HIV Status hivstat Radio
2 HIV+ test date hivposdate Text
3 AIDS diagnosis date aidsdate Text
4 HIV/AIDS provider hivpcp Note

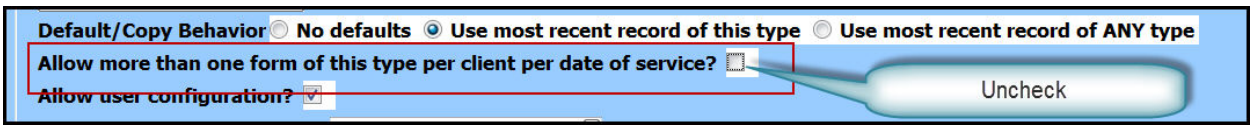
2. Preview an e-chart multiple times during construction
    1. Check the "Allow more than one from of theeis type per client per date of service"
    2. Click Preview
    3. For printing click Print
        1. Save the Record
        2. After the print preview displays Cancel
    4. User will be able to preview e-chart again
    5. Uncheck the "Allow more than one form of this type per client per date of service" for e-charts that are limited to one per


Component Definition
ID CCANUP
Title CC: ANNUAL UPDATE
Options
To certify a record is complete and locked, the following signatures are required:
HH CASE MGM
Check Box
Default/Copy Behavior
No defaults
Use most recent record of this type
Allow more than one form of this type per client per date of service?
Allow user configuration?

MAIN
Query
Next
Previous
Add
View
Update
Remove
previeW
Lock
Clone
Exit


CC: ANNUAL UPDATE
Medical Needs
Dental/Vision
Med Adherence
Side Effects/ADLS
Mental Health
Substance Abuse
Housing/Finances
HIV Status
CDC-defined AIDS
HIV-positive not AIDS
HIV-positive, AIDS status unknown
HIV+ test date
----- HIV/AIDS Status. Check = a "YES" response -----




Default/Copy Behavior
No defaults
Use most recent record of this type
Use most recent record of ANY type
Allow more than one form of this type per client per date of service?
Allow user configuration?
Uncheck

3. Special fields
    1. New special fields added to allow user to move to various screens in EHR
        1. Enter the tag for the screen.

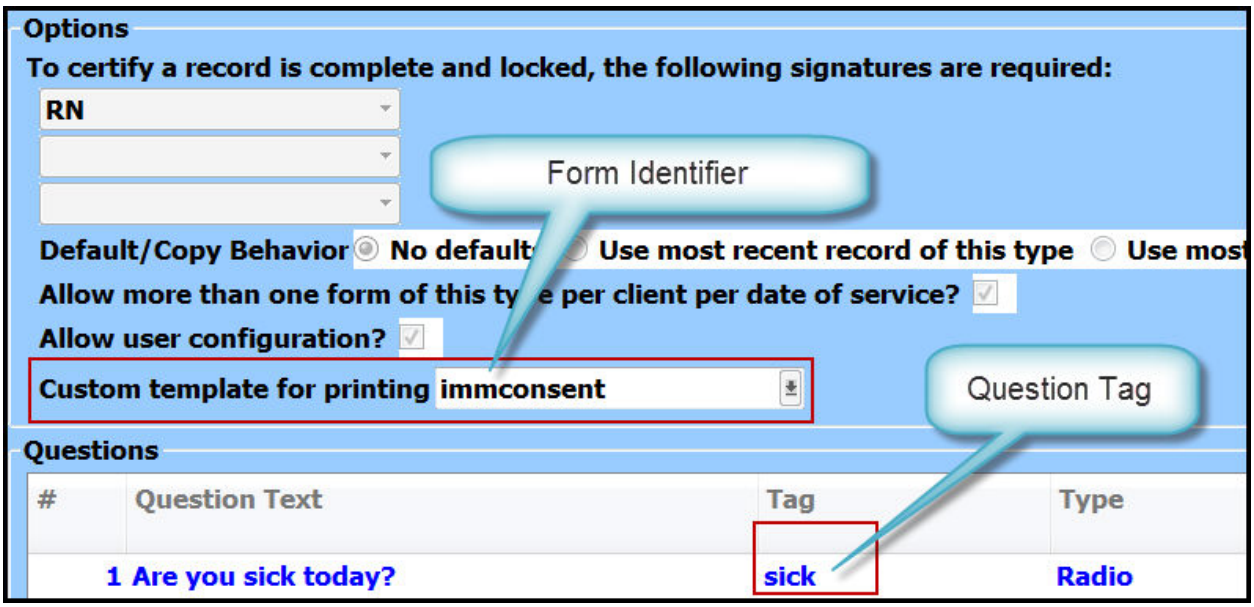
2. Type is Special

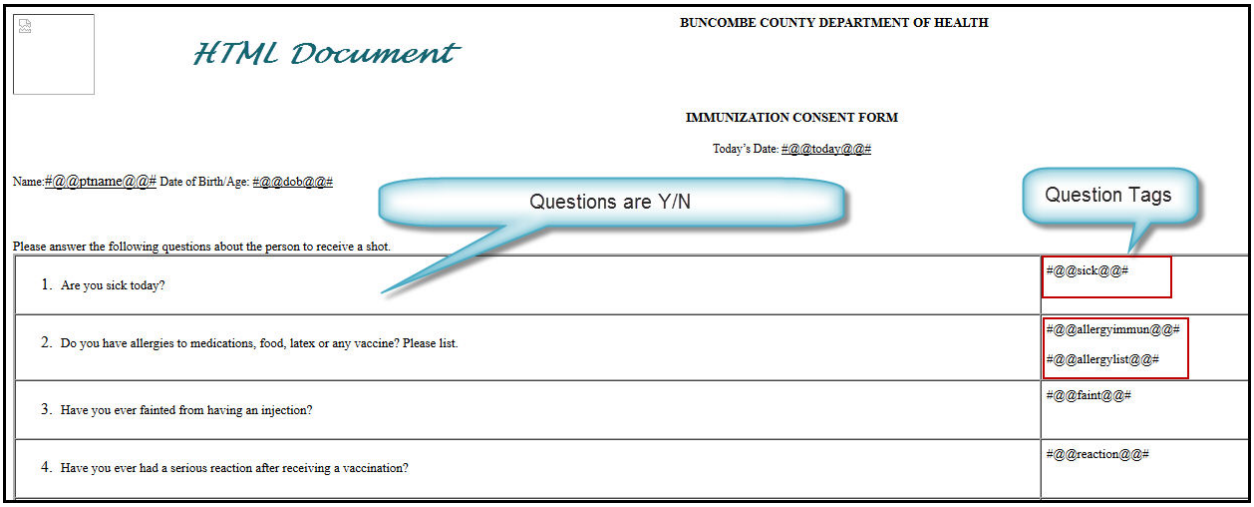
2. Screens and tags:
    1. Allergies = docallergy
    2. Medication screen = medorder
    3. Lab Orders = laborder
    4. Referral Orders = reforder
    5. Appointment Orders = apptorder
    6. X-Ray Orders = xrayorder
    7. Immunizations = immun
    8. TST (PPD) = ppd
    9. Vital Signs = vitals
    10. Lab Review = labreview
    11. Problem List = problems
    12. Outprocessing = outprocorder
    13. To move to another e-chart
        1. Tag = echartID. **Example** echartFPEXAM
        2. Type = Special

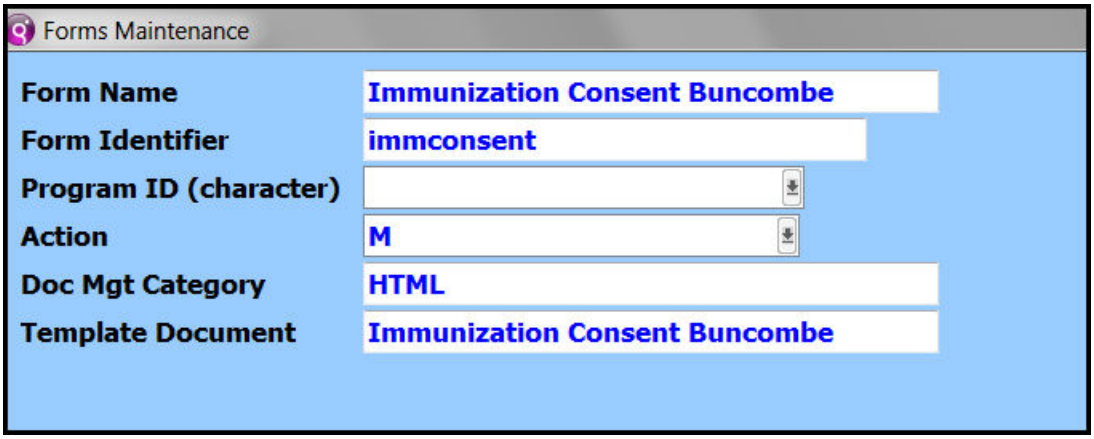
4. Add a Template
    1. Allows user to establish a form that can be signed and printed from the e-chart
        1. Create the e-chart
            1. Questions and responses should be formatted carefully so the answers will make sense on the form
            2. Best used for Y/N questions
        2. Create the form:
            1. Question Tag becomes the tag for the forms
                2. Example: question tag = sick; form tag = #@@sick@@#

See the section on creating and setting up intake forms

3. Load form into the forms table
4. In the e-chart insert the Forms Identifier into the Template field

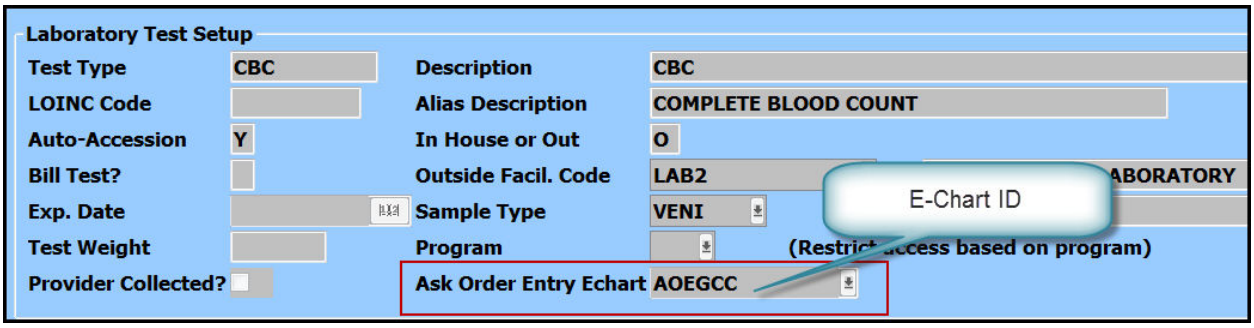

Options
To certify a record is complete and locked, the following signatures are required:
RN
Form Identifier
Default/Copy Behavior
No default
Use most recent record of this type
Use most
Allow more than one form of this ty e per client per date of service?
Allow user configuration?
Custom template for printing
immconsent
Question Tag
Questions
Question Text Tag Type
1 Are you sick today? sick Radio


HTML Document
BUNCOMBE COUNTY DEPARTMENT OF HEALTH
IMMUNIZATION CONSENT FORM
Today's Date: #@@today@@#
Name:#@@ptname@@# Date of Birth/Age: #@@dob@@#
Questions are Y/N
Question Tags
Please answer the following questions about the person to receive a shot.
1. Are you sick today? #@@sick@@#
2. Do you have allergies to medications, food, latex or any vaccine? Please list. #@@allergyimmun@@# #@@allergylist@@#
3. Have you ever fainted from having an injection? #@@faint@@#
4. Have you ever had a serious reaction after receiving a vaccination? #@@reaction@@#


Forms Maintenance
Form Name
Immunization Consent Buncombe
Form Identifier
immconsent
Program ID (character)
Action
M
Doc Mgt Category
HTML
Template Document
Immunization Consent Buncombe

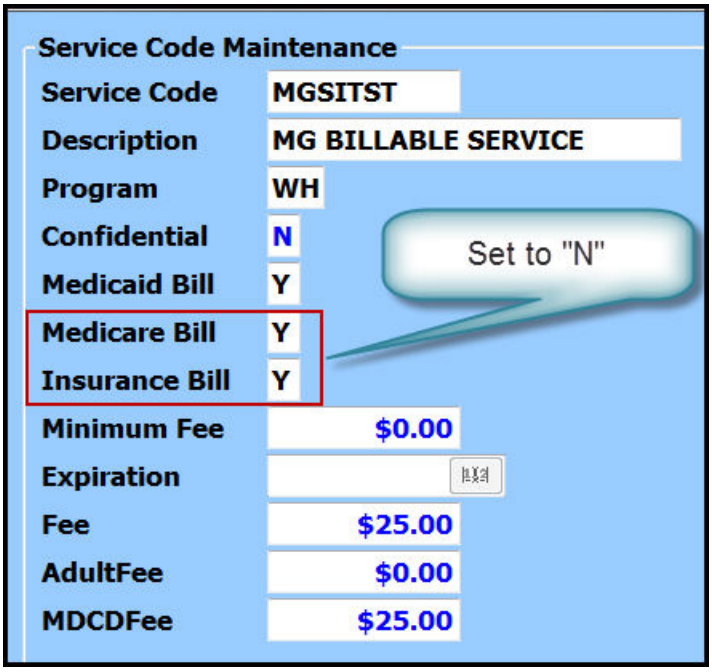
Lab Maintenance

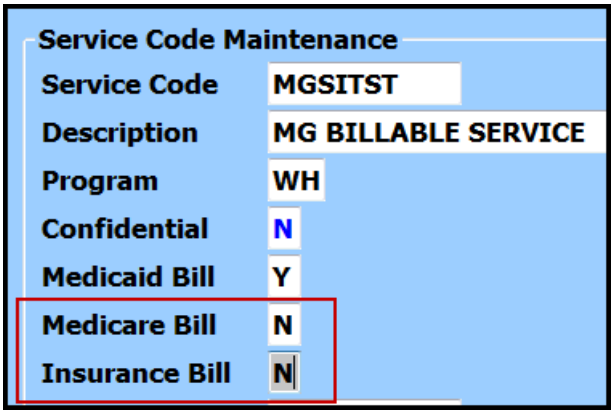
1. Ask Order Entry
    1. Allows form creation when a lab is ordered and requires a detailed form in addition to the order
    2. Create an e-chart to match the form
    3. Create the form: See Form creation from an e-chart
    4. Lab Maintenance screen
        1. Query or Add the lab if it does not currently exist
        2. New field called Ask Order Entry E-Chart
            1. Enter E-chart ID
            2. System pulls this e-chart when the order for the lab is generated

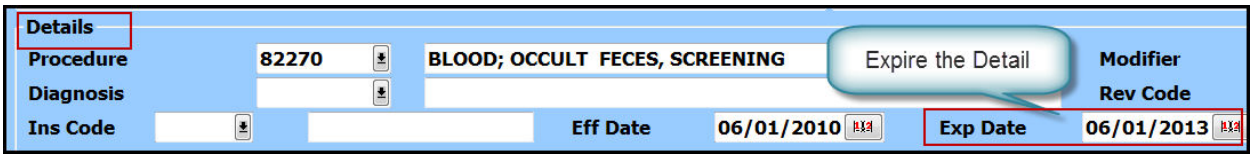


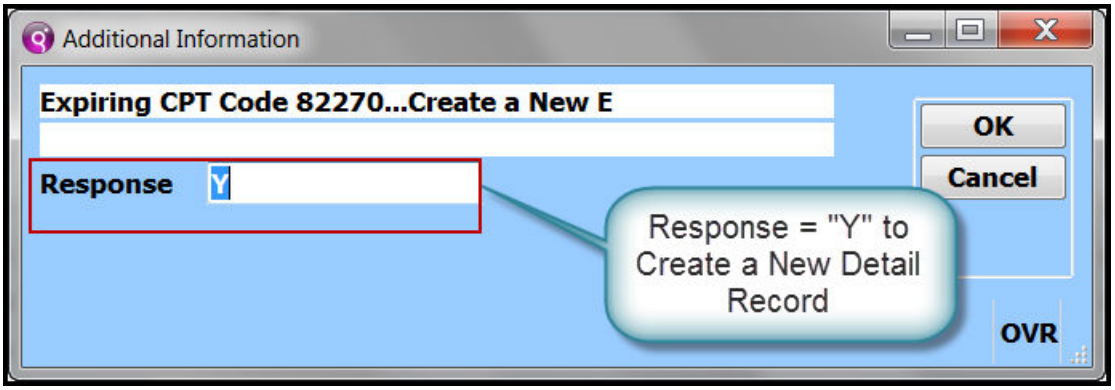
Service Code Table: Michigan Only

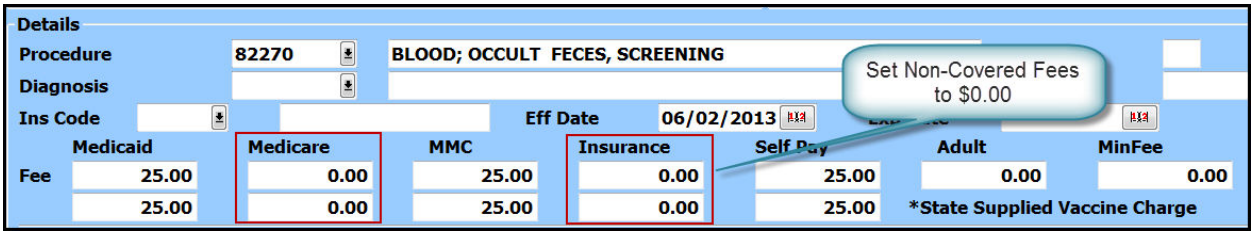
1. Non-covered services by a Secondary Insurance
    1. Changes made to assure that non-covered services will be reflected in the Medicaid Billing File
        1. Services are not covered by:
            1. Private 3rd party insurance
            2. Medicare
        2. Services are billable to Medicaid
    2. To correct a current service code
        1. Access the ServCode table from the Maintenance Menu
        2. Query the service that is billable to Medicaid but not to the patient's other Insurance
            1. Update
            2. Medicaid Bill = Y
            3. Medicare Bill = N (if not covered by Medicare)
            4. Insurance Bill = N
            5. OK
        3. Choose Cptupd
            1. Select the current Detail Record that has a Medicare and/or Insurance amount
                1. Expire the current Detail Record
                2. Enter Y to create a new Detail Record
                3. Change the Medicare amount to $0.00 if applicable
                4. Change the Insurance amount to $0.00
                5. OK


Service Code Maintenance
Service Code
MGSITST
Description
MG BILLABLE SERVICE
Program
WH
Confidential
N
Medicaid Bill
Y
Medicare Bill
Y
Insurance Bill
Y
Set to "N"
Minimum Fee
$0.00
Expiration
Fee
$25.00
AdultFee
$0.00
MDCDFee
$25.00


Service Code Maintenance
Service Code
MGSITST
Description
MG BILLABLE SERVICE
Program
WH
Confidential
N
Medicaid Bill
Y
Medicare Bill
N
Insurance Bill
N


Details
Procedure
82270
BLOOD; OCCULT FECES, SCREENING
Expire the Detail
Modifier
Diagnosis
Rev Code
Ins Code
Eff Date
06/01/2010
Exp Date
06/01/2013





3. To create a new code:
    1. Add the new service code with N in the Medicare and/or Insurance Bill fields
    2. Enter $0.00 in the Fee fields for Medicare and/or Insurance fields

Services may be covered by Medicare and not Insurance or not covered by Medicare but covered by Insurance. Set the fees to reflect the service coverage.

New Tables, Loads and Permissions

New Tables

1. appadvice: Used for processing 824 Application Advice files
2. appadviceraw: Used for processing 824 Application Advice files
3. eligrecv Used for processing 271 Eligibility Response files
4. eligrecvraw Used for processing 271 Eligibility Response files
5. hhclaimack Used for processing 277 Claim Acknowledgement files
6. leadmedact Monroe County NY Lead Tracking Medical Actions
7. rxmeds Used in e-prescribing to store meds/prescription data
8. mnemonics Used to store the user-defined macros used throughout the system
9. mhvisit Stores OB history for maternal health programs.
10. Orderqueuelog Maintains a history of providers assigned to a particular task list item. Requires update permission if has update on the orderqueue table
11. vhndata_driver

Loads

1. A new workflow type code CT added for Child Tracking. Used in Macomb County MI only
2. An update list of CVX codes used for immunizations. Includes new codes as of 5/1/2013
3. Default workflow
4. New e-chart template